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A MONTHLY JOURNAL OF

MEDICINE AND SURGERY.

EDITED BY

DAVID W. YANDELL, M. D.

*Prof. of the Science and Art of Surgery and Clinical Surgery, University of Louisville,*

AND

THEOPHILUS PARVIN, M. D., LL.D.

*Professor of Obstetrics and the Medical and Surgical Diseases of Women, College of Physicians and Surgeons of Indiana.*



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# THE AMERICAN PRACTITIONER.

SEPTEMBER, 1876.

Certainly it is excellent discipline for an author to feel that he must say all that he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else —RUSKIN

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## Original Communications.

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### A CASE OF PODELCOMA.

BY G. W. H. KEMPER, M. D.

### WITH MICROSCOPIC EXAMINATION OF THE DISEASED STRUCTURE.

BY HENRY JAMESON, M. D.

Podelcoma, from *πους*, *ποδος*, a foot, and *ἔλκωμα*, an ulcer, is a malady affecting the feet, and sometimes hands, of the inhabitants of intertropical countries; and known by various other names, such as "Madura foot," "fungus disease of India," etc.

It is rarely seen without the tropics, and has been little studied either in this country or Europe. Miller, of Edinburgh, gives an elaborate treatise upon this subject; and in the Transactions of the Medical and Physical Society of Bombay, No. IV, for 1861, an essay is published by Dr. Carter, giving the true nature of the disease for the first time. This constitutes the principal literature upon the subject.

The extreme rarity of the disease in this country has induced me to give a detailed report of a case which recently came under my notice. This case was seen by a number of physicians, among whom was Professor Parvin, and all state that they have never before seen a similar case. In a recent conversation with Professor Dawson, of Cincinnati, he stated to me that he had never seen a case of podelcoma. The following detailed report gives the essential features in the case:

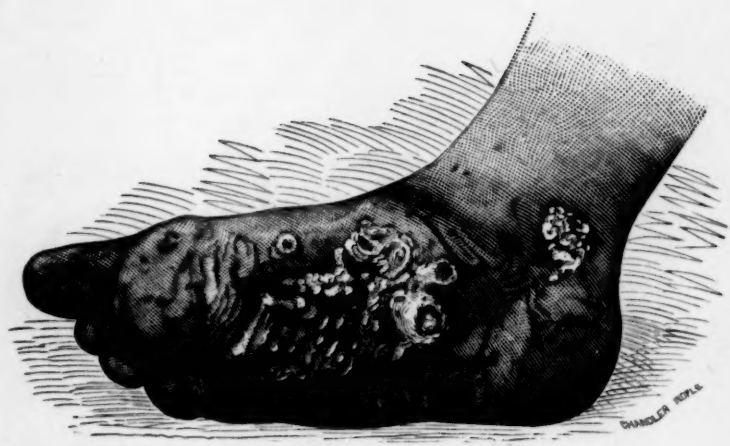
Mr. Harry Bowman, a native of Ohio, aged twenty-four years, by occupation a dry goods clerk. He has a nervous temperament, with a clear and delicate skin, yet gives no history of a scrofulous taint in the family, neither has he suffered from venereal disease. He consulted me on the nineteenth day of May, 1876, and gave the following account of his case:

About the middle of December, 1875, the right foot became swollen, reddened and painful: there was no constitutional disturbance, and it was thought to be rheumatism, and was treated with domestic remedies. At the expiration of three weeks from the beginning of the attack, the entire sole of the foot was so tender that he could bear no weight upon it. This condition continued until about the middle of the following April, when, after an intense itching of the bottom of the foot, several blebs about the size of a split pea made their appearance.

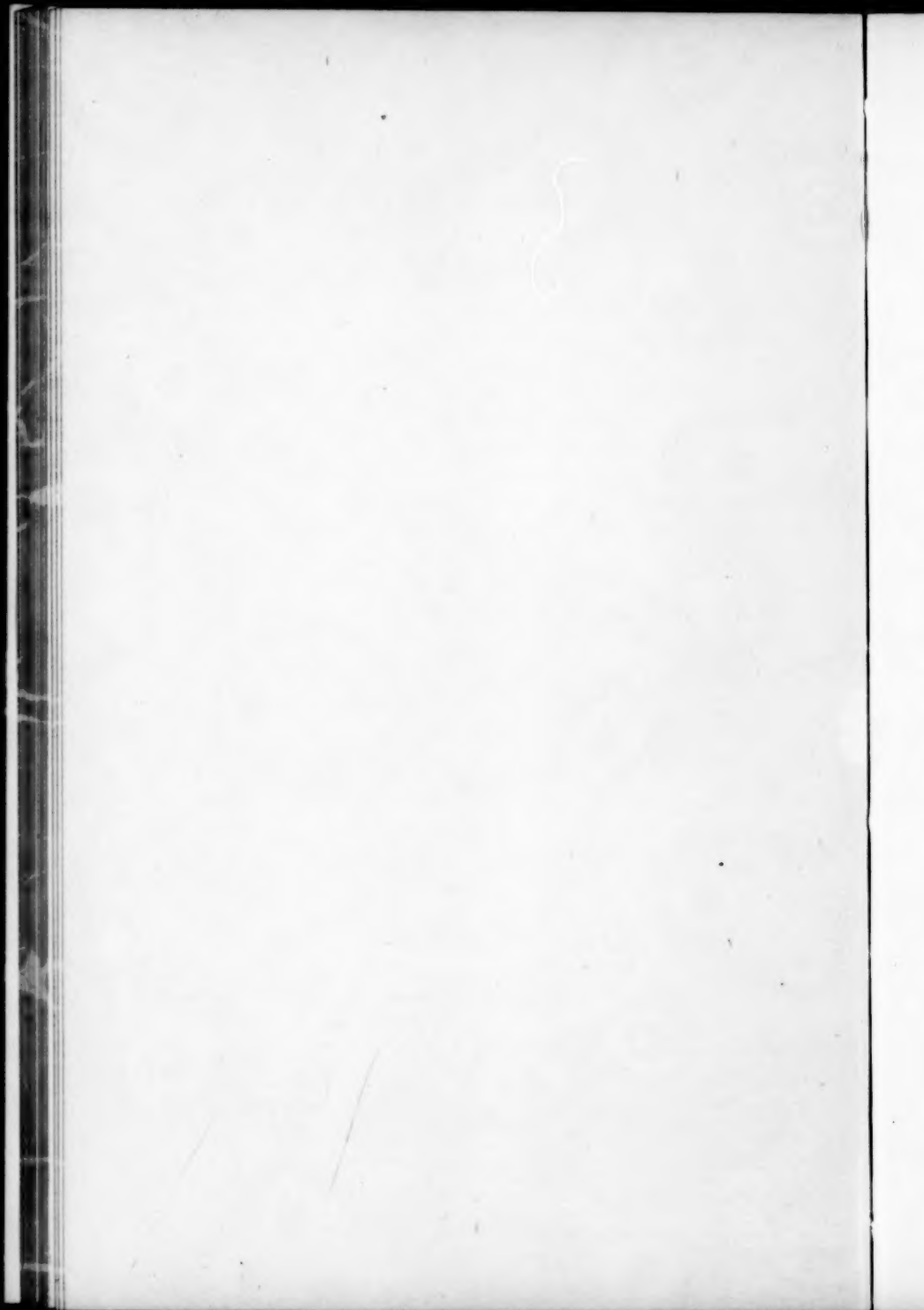
When I first saw him, some of these blebs had enlarged and otherwise changed their character; they were five or six in number, and were about half an inch in diameter. The cuticle, which was of a dirty white color, was intact, except at the center of each bleb, where a round opening existed with well defined borders. From these open centers issued daily about half an ounce of glairy fluid resembling the white of an egg, which was exceedingly offensive—a true meligeion. This discharge did not contain purulent matter, nor was pus present at any time during the course of the disease. There was but slight constitutional disturbance at any time.

Such was the condition of my patient at his first visit, after





*Fig. 1.*



which the ulcers gradually enlarged until they were separated only by undermined bands of integument; and still later, they were lost in one large ulcer at the inner side of the arch of the foot, as seen in Fig. 1. This was followed by the formation of a second, a little below and posterior to the internal malleolus, which was characterized by the same peculiar growth and offensive discharge as the first. A third and smaller ulcer appeared over the first metatarsal bone, and still later a fourth upon the bottom of the heel. The whole foot, including the toes, was greatly swollen and exquisitely painful; the slightest pressure over the diseased or healthy portion was sufficient to cause acute suffering.

Before his first visit to me, the usual routine of domestic remedies had been tried without even temporary relief. The constantly increasing pain drove him to seek medical advice. At this time I ordered a dressing composed of equal parts of acid nitrate of mercury and simple cerate, to the ulcers, with a continued application of flaxseed meal poultice to the foot.

May 21st. Since the last date his suffering has been very acute. He sleeps but little, notwithstanding the free use of opiates. I ordered laudanum to be used freely upon the poultices, and half grain doses of morphia to be given as often as prudent for the relief of pain.

May 23d. The patient has only had temporary relief while under the influence of opiates. In addition to the local measures named, I directed the foot to be painted with tincture of iodine three times daily. He was also given iodide of potassium, in doses of fifteen grains three times a day. Hydrate of chloral was tried in large doses on the night of the 22d, without much benefit.

June 2d. There is no perceptible improvement, the ulcers have gradually increased in size and are constantly painful, and at times severely so. I applied chromic acid thoroughly, and after the thickened cuticle was destroyed the tar ointment was used. This proceeding so increased his suffering that he was relieved only by the free use of injections of morphia into the calf of the leg, and immersion of the foot in warm water.

June 5th. The condition of the foot is somewhat improved. He has had less pain for the last two days, and rested better at night. Nitric acid was applied to the ulcers instead of the chromic, on account of the intense suffering produced by the latter.

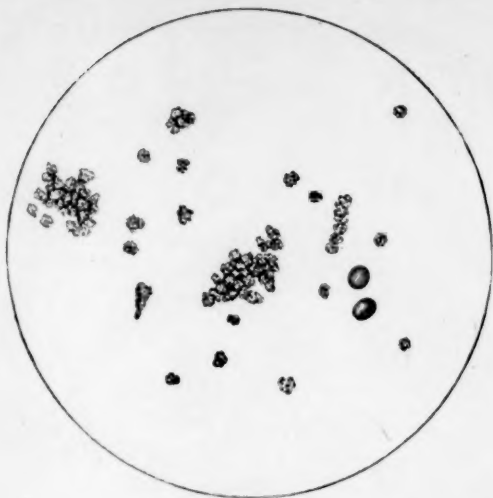
June 11th. The smaller ulcers have not increased since the last date, and the larger one has decreased its diameter nearly one-half. The healed portion presents a smooth appearance. For two nights he has suffered greatly with pain, which seemed to originate in the cicatrix, passing up the limb to the spine. It was paroxysmal and manifested periodicity, recurring each night about eleven o'clock. With a view of counteracting this tendency, I administered large doses of sulphate of quinia. Notwithstanding the disposition of the ulcers to heal, the foot yet remains greatly swollen and very tender on pressure. Hypodermic injections of morphia give only partial relief.

June 15th. The suffering is yet so acute that at times signs of opisthotonos are present, and chloroform was administered for relief. The cicatricial tissue has broken down, and the ulcers are larger than at any previous time. His general health has steadily but markedly declined. For the past month his rest has been greatly disturbed, and his appetite has gradually and almost entirely forsaken him.

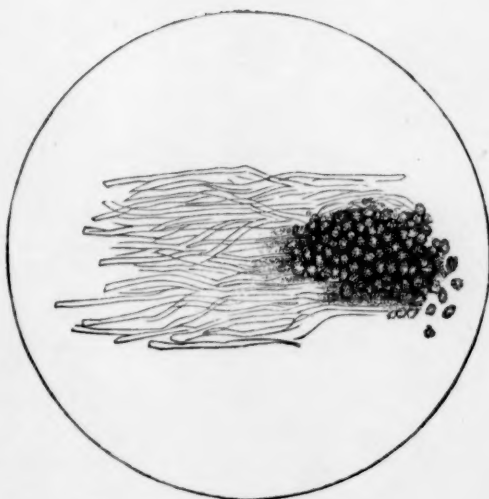
The means named, as well as others not mentioned, having been thoroughly tried, with no prospect of success, and in view of the fact that my patient's strength was failing, I advised amputation, which met with his hearty approval.

June 16th. Assisted by Drs. Winton and James, Drs. Boyden and Leech also being present, I amputated the leg at the junction of the lower and middle thirds, so as to avoid the diseased tissue above the ankle-joint. Esmarch's bandage was applied, commencing above the ulcers, and about two ounces of blood were lost.

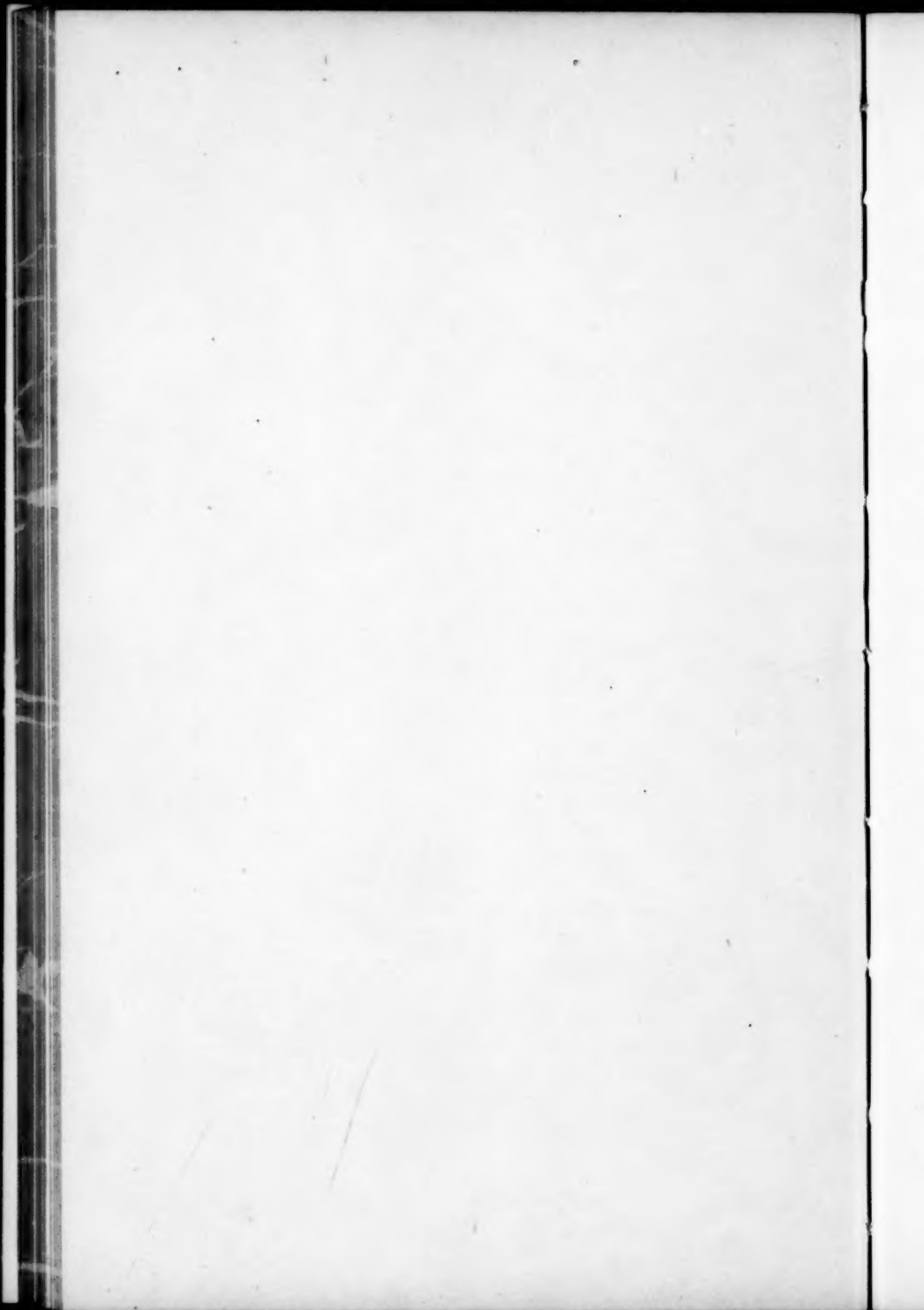
June 19th. The healing process is progressing rapidly in the stump, his general health is improving, and all indications are favorable to speedy and permanent recovery.



*Fig. 2.*



*Fig. 3.*





*Dr. G. W. H. Kemper—Dear Sir:* The external gross anatomical changes which existed in the foot at the time of amputation have been so clearly described in your report of the case, and moreover their having undergone certain changes due to immersion in alcohol, which impairs in a measure their value, they will simply be noticed before giving the appearance of the tissues upon dissection.

The larger ulcer, which is admirably represented at Fig. 1, was depressed below the general surface at least one-fourth of an inch, having sharp and well defined borders, was covered with a white fluffy substance. This substance was friable, breaking down readily under the scalpel, and presenting to the naked eye the appearance of mould or fungus, evidenced by difficulty in determining the position of its surface. This difficulty is probably due to a peculiar method of reflection or absorption of the rays of light by some of the various species of fungi. A probe being passed over the surface, discovered several openings passing down into the deeper tissues of the foot, but in no instance coming in contact with dead bone.

The smaller ulcers were probed in a like manner, and the openings were found to pass tortuously between the deeper muscles.

Upon laying the foot open, these canals could be distinctly traced, and were found to involve nearly all of the deeper muscles, which in many places were completely disintegrated, giving place to masses of the same material found upon the surface of the ulcers.

When examined with the one-fifth inch objective, with the B eye-piece, magnifying about two hundred diameters, which was ample to bring out the structure of this substance, it presented numerous granulated bodies, as seen at Fig. 2. They were rough and irregular in outline, yellowish in color, and refracted the light in such a manner as to give them a brilliant hue. These tubercles, variable in size, were massed together in mulberry-like groups, but bore no special relation to each other, except in one instance, when they assumed a chain-like form, as seen in the right side of the field in Fig. 2.

It was further noticed that the tortuous canals leading from the ulcerous surfaces, lead into cavernous openings in the bodies of the muscles, and these loculi were filled with a mass of the white tubercles, as represented at Fig. 3, which also serves to illustrate the relation of this material to the normal tissues. These minute spores were accompanied nowhere with any other anatomical element, which is strong evidence in proof of mycetoma. Vegetable parasites subsist upon the wasting substances of the body they attack; and were they simply present, taking no part in disintegration, we would certainly find associated with them the débris of the wasting tissue. That these white tubercles are vegetable spores there can be no doubt; but as to their identity with the *chionophé Carteri* of Berkley, which is productive of the Madura foot, we can not be absolutely certain, as the identity of the different species of vegetable spores can not be established by any description given of their forms and appearance. "There is no branch of science whose synonymy is more burdensome. It is almost a hopeless task to attempt to identify the species of authors by description alone, the plant itself being necessary for comparison." The protean character of a single fungus would require long and continued observation to properly classify the many forms assumed during its brief existence. To this is due the contrariety of belief of different authorities concerning vegetable parasites.

Notwithstanding the difficult task of properly locating these ever changing organisms, we can but conclude that they are identical with those that are described by Carter and others; and while there may be points at variance in the clinical history of the case and the morbid appearance of the tissues, yet the essential factor in the disease seems to be the presence of this minute spore, with the power of reproducing itself in the living tissues, and sustaining itself by their destruction.

Many questions of interest suggest themselves in connection with this case:

First. As to the origin and introduction of the mycelium, for it will be remembered that in many cases the symptoms

are manifested internally long before the integument is attacked, which might lead to the error of belief in their spontaneous generation in the blood. "We need not resort, however, to the unsatisfactory theory of spontaneous or accidental origin, if indeed we are able to conceive of any vast assemblage of organized structures, permanently reproductive and identical through centuries, being the result of chance." The delicate mycelium penetrates the hardest wood, and the vegetating fibers are so extremely minute that they find ready entrance through the pores of the densest substance.

Second. The conditions which must be present to favor their propagation, and the means by which they may be destroyed and these conditions counteracted.

INDIANAPOLIS.

### SOME OBSERVATIONS ON THE NATURE AND TREATMENT OF CHOLERA INFANTUM.\*

BY B. D. KEATOR, M. D.

The term cholera infantum, as generally used, includes too much—so much as to embrace nearly all the stages of both diarrhœa and dysentery. In this paper I would restrict the term to that disease of young children occurring during the hot season, perhaps more frequently in large towns or cities, characterized by both vomiting and purging. The disease may approach slowly, with slight diarrhœa and occasional vomiting; but more often it comes on suddenly, with few premonitory symptoms; the vomiting, if not arrested, being soon followed by cold extremities, pinched features, sunken eyes, pallid countenance, spasmodic symptoms, great restlessness, moaning, turning the head on the pillow, approaching

\* Read before the Champaign County (Ill.) Medical Society, at its meeting in Tolono, June 15, 1876.

coma, and finally death from exhaustion or a condition known as hydrocephaloid.

As we seldom have cases of genuine cholera infantum before the thermometer has stood for some days between 80° and 90° Fahr., the remote cause of the disease appears to be extreme heat, operating on the impressible nervous systems of children; and the approximate cause is found in some sudden alternation of temperature, as hot days attended by cool showers or followed by cool nights.

During this hyperæsthetic and impressible condition of system, more immediate exciting causes will be found in errors of diet, dentition, torpidity of the liver, acidity of the stomach, vitiated or decomposed bile, retrocession of heat-rash, etc.

Dr. McBride, of Berea, Ohio, in an able article on this disease (*Lancet and Observer*), believes this last—heat-rash—to be the sole cause of the disease. While this can not be conceded to be strictly so, yet according to my observation many of the most sudden and alarming cases come from this cause. Time and again have children been brought to me with this rash, who, in a few days after, were attacked suddenly with cholera infantum. In such cases the irritability of the stomach will prove very persistent, and the skin, from the first, present a more blanched and exsanguine appearance than usual.

Another able writer, Dr. J. P. Mann (*New York Medical Journal*, Vol. X, No. 1), believes the cause of the disease to be decomposition of bile in the gastro-intestinal track.

A majority of the physicians of my acquaintance with whom I have conversed on the subject, attribute the disease to torpidity of the liver, which plainly needs a little mild chloride of mercury, or *hydragyrum cum cretâ*, for its obstinacy. That there is an absence of the yellow, or so-called "bilious" appearance of the stools, is often, but not invariably, true; but whether this is the cause or a result of the disease, might be a subject for discussion. The icterode hue of countenance, common in cases of arrest of biliary secretion, is not generally found.

To return: It would thus appear that while extreme heat

may be fairly regarded as the remote cause of the disease, the proximate cause may vary. The disease can often be arrested by timely and judicious treatment in its first stages; but if not, the acute form generally proves fatal in a time varying from a few hours to a few days; or else, the vomiting ceasing, it passes into the chronic form, the duration of which is very indefinite.

According to a recent work (Steiner's Compendium), "the pathological changes—most frequently found post mortem, affecting the stomach, small intestines, and occasionally the ascending colon—consist in injection and swelling of the mucous membrane; and when the course of the case is very rapid, extensive destruction of the epithelial coat: ecchymoses are also sometimes seen. Acute enlargement of the mesenteric glands and general anæmia of the organs, especially of the brain, which often also gives evidence of fatty degeneration and œdema; hyperæmia of the kidneys, and in occasional cases acute parenchymatous nephritis." Though "most frequently" it appears there is found anæmia of the brain, yet not always, for "the brain is sometimes found congested with serous effusion into its ventricles." (Maxson.)

Where the head symptoms come on early, before there has been much drain on the system by diarrhœa, we should investigate as closely as possible, and endeavor to ascertain whether the brain and its membranes are in a hyperæmic or anæmic condition, and conduct our treatment accordingly. It appears to me there is too much tendency towards regarding all these head symptoms of cholera infantum as the result of cerebral anæmia, and thus leading not infrequently to injudicious treatment.

As preliminary to touching upon the treatment of this disease, I would not fail to mention the flannel bandage, to be worn about the abdomen as a means of prevention; and to protest against the weaning of children (except through necessity) during the season of the year when this disease prevails. In a case of real cholera infantum, in which there are both vomiting and purging, it has always appeared to me that the

vomiting did more immediate harm than the purging. It appears to be in some way directly connected with the development of cerebral difficulties, and hence our first aim should be to allay the gastric irritation. For this purpose, small doses of hydrargyrum submuriate, triturated with white sugar and placed upon the tongue, often prove effectual. Some prefer to add a little plumb. acetate, and both are used with considerable success. The cerium oxalate, in doses of one-sixth to one-fourth of a grain, repeated at short intervals, I regard quite as successful, if not more so. But the best remedy of all, in my opinion, is creasote or carbolic acid with an alkali. Add to a goblet of water two or three drops of creasote and a pinch of sodium bicarbonate. Of this give a teaspoonful often as required, withhold all drink for a time, place a sinapism weakened with flour over the stomach, and you will generally succeed. Or, in place of this, a drop of creasote added to an ounce and a half of lime-water, and given in teaspoonful doses, will answer as well.

If there is evidence of torpidity of the liver, half to a grain of hydrargyrum submuriate, guarded by as much Dover's powder, may be given once in six or eight hours, until the function of that organ be restored. I say this *may* be done, and I have often done it; but of late I have a better remedy. Whether there be decomposition of bile in this disease, as supposed by a writer before quoted (Mann) or not, I can not say; but I can certify that the remedy he proposes is an excellent one, almost specific. Here is the formula:

R.	Aloes socot pulv.,	. . . . .	} aa ʒi
	Potassii sulphat.,	. . . . .	
	Sodii bicarbonat.,	. . . . .	
	Caryophyl. pulv.,	. . . . .	ʒss

Mix, and divide in twelve powders. For use, put one of the powders in a cup, and add three tablespoonfuls of hot water. Dose, one teaspoonful, warm as it can be taken every half hour, until bright yellow bile appears in the stools.

This is the original, with directions; but I use it somewhat differently. I keep it on hand in quantity, using it both for



adults and children for all bilious symptoms. In cases of cholera infantum, put a teaspoonful of the powder and a tablespoonful of sugar in a teacup, and fill with boiling water. When cool enough to use, give one teaspoonful every fifteen or twenty minutes, withholding drink until vomiting ceases, then every hour until it acts on the bowels as before mentioned. Though having the appearance of a nauseous dose, I find this to remain on the stomach when scarcely anything else will.

But to return: After the vomiting is checked, our attention should next be given to the diarrhœa. The practice of giving astringents and opiates, with the intention of suddenly checking the diarrhœa, is, I am satisfied from experience, decidedly harmful not to say dangerous.

Opium, or even morphia, may be given in most cases with benefit, but in such minute doses as to secure and keep up, as long as required, its soothing and stimulating influence without reaching its stupefying and narcotic effects. If the brain is in a condition of anæmia, what will better tone and send the blood to its empty vessels than stimulating, not depressing, doses of opium?

The effect of subnitrate of bismuth, combined with small doses of Dover's powder—say three to five grains of the former and one-fourth to one grain of the latter—is sometimes very satisfactory. It appears to exert a soothing and quieting influence on the irritated mucous membrane of the stomach, and thus diminishes general nervous excitement. A convenient form of administration is to add it to the ordinary chalk mixture, in the proportion of thirty grains to the ounce of chalk mixture, with the addition of paregoric in some cases. This, according to the old adage, must be "shaken before taken."

The only astringents allowable in the early stage of cholera infantum proper, in my opinion, is zinc oxide. This, besides its astringency, is a nervine, and like the bromides lessens cerebral hyperæmia, and is, on the whole, one of the best remedies we possess for this disease. Not only will it quiet general

nervous irritability, but, like the bismuth subnitrate, it has a soothing influence directly on the irritated gastro-intestinal mucous membrane. There may be some who will take exceptions to this, but such is my opinion after an extensive use of it. To neutralize acidity, as well as prevent the possible formation of zinc salts, in the stomach, it should be combined, when used in this disease, with sodium bicarbonate, in about the proportion of eight grains of the sodium salt to each drachm of the zinc.

The actions of creasote and carbolic acid are nearly the same, but what difference there is appears to be in favor of the creasote in this disease. The beneficial effect of these medicines is not limited to the arrest of vomiting; but they appear to be among the best means of checking the diarrhœa also, and from their antiseptic properties of preventing fermentation in the stomach, as well as tending to lessen the destructive changes likely to occur in the mucous membrane. In using carbolic acid, the following formula from Professor Davis, of Chicago, is a very excellent one:

R. Crystal carbol. acid,	grs.iii
Glycerine (Bower's),	℥ss
Paregoric,	℥i
Water,	℥iss

Mix. Dose, twenty drops every half hour, until the vomiting ceases; then every two hours. (*Vide* Half-Yearly Compendium, January, 1873.)

A favorite formula with me for administering creasote and morphia in proper doses is as follows:

R. Creasote,	gtt.xvi
Morphia sulph.,	gr.ii
Ess. peppermint,	℥i
Syr. rhei. aromat.,	℥x
Glycerine (Bower's),	℥x

Mix. To a child of one year give from ten to fifteen drops in a teaspoonful of milk, every two hours while awake. If in the vomiting stage, only a few drops, frequently repeated, with lime-water and milk, withholding drink.

Much benefit is often obtained in this disease by the use of mucilages; especially should they be given during the use of creasote or carbolic acid. Among these I prefer salep, twenty grains to four ounces of hot water; and next gum arabic.

After the first stages of the disease have passed by, the discharges often become less frequent but more copious, the disease passing into a chronic stage. Here the treatment must be tonic and supporting. Now, with the exception of iron, in cases where it is plainly indicated, no tonic can come in competition with salicin, given in half to grain doses to a child one year old, three or four times daily. It appears to be not only better than quinia, in restoring appetite and aiding digestion, but is the best remedy we have in moderating the diarrhœa, which it does in a gradual and apparently natural way, without the development of the complications following its arrest by ordinary astringent treatment.

We meet with cases of this disease, in its chronic form, which baffle all our skill to arrest, and our only hope is to bridge them over to the approach of cool weather. Such cases I would trust to good nourishment, port wine, and salicin. Whenever the discharges become purulent, or there is any evidence of intestinal ulceration, I have found potassium chlorate, combined with a little Dover's powder, worthy of much confidence.

In those cases which supervene on retrocession of heat rash—*lichen tropicus* of Dr. McBride, and which I am confident constitute a large percentage of the worst cases we meet with every season—our aim should be to determine the blood to the surface, recall the rash if possible, and so relieve the congested mucous membrane of the stomach and bowels. For this purpose, no single remedy equals belladonna. Dr. McBride gives it in half drop doses of the fluid extract, until the cuticular circulation is reëstablished. This dose was for a child of one year. I would advise, in addition, that the child have a warm mustard bath, or be enveloped in a shawl or other woolen piece, wrung out of warm mustard water, and

cooling drink be given. In such cases, we often find the mucous membrane of the mouth very red and hot, and the child ready to swallow anything in a liquid form, be it even a nauseous dose of medicine, for the sake of drink. In these cases, nothing appears to give so immediate relief as scraped ice, in half teaspoonful doses, or in the form of ice cream.

As it has been shown that the brain has been found, post mortem, in opposite conditions, the treatment should, so far as possible, be adapted to the condition present in each case. If there be evidence of cerebral hyperæmia, the best remedies, according to my observation, are the bromides and zinc oxide. The bromides must be given, in such cases, in sufficient doses to control spasm and compel sleep. I have had recoveries from apparently hopeless cases of this character, by keeping the patients asleep by the use of potassium bromide, for several days in succession, only disturbing them at proper intervals for the administration of nourishment in the shape of milk or sweet cream. We thus give the oppressed brain the rest it needs for recuperation. Warm foot-baths, and frequent bathing of the head with cool water, are also proper additional means.

On the contrary, as is more often the case, if the brain give evidence of anæmia, belladonna, from its action on the extreme capillary circulation, and nux vomica, from its power to arouse nerve energy, are the most reliable means at our command. Although opium and belladonna are antagonistic, in some respects, yet it appears to me that when alternated in the proper dose of each, they have been co-workers for good in cerebral anæmia. The head should not be elevated, and should be kept at a warm, even temperature by a woollen cap. These means should be aided by nourishment in the shape of brandy and cream, or pounded raw beefsteak and wine.

TOLONO, ILL.

REDUCTION OF DISLOCATION OF THE HIP-JOINT  
BY MANIPULATING THE FEMUR OVER A  
FULCRUM PLACED IN THE GROIN.

BY GEORGE SUTTON, M. D.

In the April number of the American Practitioner, on page 225, are rules for the reduction of dislocation of the hip-joint by making the femur a lever and manipulating it over a fulcrum placed in the groin. In the second rule occurs a typographical error which I wish to correct. I am made to say, "If the dislocation is into the ischiatic notch, the femur is to be flexed over the fulcrum, which movement will lift the head of the bone out of the ischiatic notch, and at the same time raise it high enough to pass the rim of the acetabulum; the knee is then to be moved *inward*." This should read, "the knee is then to be moved *outward* to place the head of the bone over the cotyloid cavity; which, by so doing, will enable the surrounding muscles to effect the reduction." So glaring a mistake would readily be detected and probably be regarded by most persons as a typographical error. Whether this mistake was made by myself or the printer I do not know, as I find, on examination, that it does not occur in the copy of the manuscript I have in my possession.

Since the paper alluded to was published, I received a professional call from Ohio county, and reduced another dislocation of the hip-joint without difficulty by manipulating the femur over a fulcrum. The dislocation was of the ischiatic variety, of four weeks' duration, and had resisted all the efforts made to effect its reduction. The case was about to be abandoned, but the two physicians in attendance—Doctors H. T. Williams and W. H. Sullivan, prominent physicians of Rising Sun, the county seat of Ohio county—hearing of the facility with which several dislocations of the hip-joint had been reduced at Aurora, by the aid of the fulcrum, after all other means had failed, addressed me a letter on the 26th of April

last, inviting me to meet them in the case of a dislocation of the femur, if I did not think it one of too long standing, as they informed me the bone had been out of place twenty-eight days. Being anxious to avail myself of every opportunity to try this mode of reducing dislocation of the hip-joint, I at once accepted the invitation and visited Rising Sun the next day, April 27, 1876, accompanied by my son, Dr. Harley H. Sutton.

We found the case as represented, the head of the femur lodged in the ischiatic notch. Originally the head of the bone was on the dorsum of the ilium, but in the efforts at reduction the bone had slipped into the ischiatic notch, from which the attending physicians could not remove it.

We proceeded to effect the reduction. From the length of time the bone had been dislocated, and the complete failure of all efforts employed to remove it from the ischiatic notch, we anticipated difficulty. Consequently I had two pads or fulcrums made of different sizes, one a piece of muslin rolled up between two and three inches in thickness, and about fifteen inches in length; the other, made of the same material, between three and four inches in thickness. Strings were tied around each to prevent unrolling. A broad board was procured nearly two feet in breadth and about ten feet in length. There were two beds in the room; these were drawn near enough together to place an end of the board on each bed. Comforts were spread on it, a pillow placed in position, and the patient lifted on to this board. This arrangement places the patient in a very convenient position for the manipulations of the surgeon, and enables both the surgeon and assistants to be close to the side of the patient, and is much better than having to manipulate on a broad bed, or in the stooping position on the floor.

Assisted by Drs. Williams, Sullivan, G. V. Stevenson—medical gentlemen of Rising Sun—and Dr. H. H. Sutton, and other gentlemen who were in the room, we proceeded to reduce the dislocation. Dr. Sullivan administered chloroform. The patient, however, did not come under its influ-



ence well, and unfavorable symptoms appearing, we placed the smallest fulcrum in the groin, one end of which was held by Dr. Williams and the other by Dr. H. H. Sutton. I then flexed the thigh over it; the patient struggled considerably, and Dr. Sullivan again administered the chloroform, which in a few moments partially produced the desired effect, without this time alarming symptoms. The limb during the time had been kept slightly flexed over the fulcrum. I now increased the flexion, which by lever power raised the head of the bone at once out of the ischiatic notch, and also high enough to pass over the rim of the acetabulum. I then flexed the leg upon the thigh, and with my right hand on the bottom of the foot pushed the knee forward toward the sternum, to place the head of the femur on a level with the cotyloid cavity. I then with my left hand moved the knee outward, and while doing so moved it upward and downward, which, from the lever power that I had, broke up the adhesions and enabled me to move the head of the bone along the line by which it could most readily return to the socket. While making these movements, which required but little force, I slightly raised the knee—the leg still abducted—and felt the bone glide into its proper place.

The thigh could now be moved in any direction without difficulty, the toes no longer turned inwards, and the limb was of the proper length. Dr. Williams measured the distance of the trochanter from the superior spinous process of the ilium, and found no difference from that of the opposite leg. The dislocation was reduced. The time required to effect the reduction was probably between five and ten minutes. The patient has since recovered, and is again attending to business.

The difficulties which two experienced physicians had met with in their attempts to reduce this bone—the length of time (four weeks) the limb had been dislocated increasing the complications of the case, the ease with which all obstacles were overcome, the adhesions broken up, and the reduction accomplished, even while the patient was only partially under the

influence of chloroform—makes this not only a test case, but presents facts which, I think, prove beyond all doubt the value of this mode of reducing dislocations of the hip-joint. We claim for this method the power of controlling, guiding, and raising the head of the femur; consequently by this plan we avoid the danger of rolling the bone around the outside of the cotyloid cavity, also of changing one form of dislocation into that of another, and producing unnecessary contusions, lacerations, or injury to the parts. We also claim for this mode the best means of guiding the head of the bone along the *only* line by which it can return to the socket, and the best means of raising the head of the femur over the rim of the acetabulum, by which we overcome one of the principal difficulties to the reduction of dislocation of the hip-joint. And if the head of the bone does not readily pass through a rent in the capsular ligament—"button-hole rent"—we claim for this plan the best mode of enlarging this rent, by which the femur can again return to its proper place.

The full particulars of the above case, with observations on the value of manipulating the femur over a fulcrum in reduction of dislocations of the hip-joint, were presented in a report to the Indiana State Medical Society, at its last meeting, from which the above is an extract.

This now makes the fourth case in which dislocation of the hip-joint has been reduced with remarkable facility, after all other means had failed, by manipulating the femur over a fulcrum. Up to the present time we have no failures to report. Three of the cases have been on the dorsum of the ilium, and one into the ischiatic notch.

Since making this last reduction, I change the second rule of the series presented in the April number of the Practitioner, so as to read as follows:

"If the dislocation is into the ischiatic notch, the femur is to be flexed over the fulcrum, which movement will lift the head of the bone out of the ischiatic notch, and at the same time raise it high enough to pass over the rim of the acetabulum; then the leg is to be flexed upon the thigh, and with

the hand on the bottom of the foot, the knee is to be pushed forward toward the sternum to bring the head of the femur on a level with the cotyloid cavity; then the knee is to be moved outward to place the head of the bone over the acetabulum, and enable the surrounding muscles to effect the reduction."

AURORA, IND.

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### AMBLYOPIA FROM RETINITIS PIGMENTOSA.\*

BY T. D. MANNING, M. D.

M., aged thirteen years, applied in June, 1875, for admission to the Texas Institute for the Blind, but the spring term of that institution being well nigh over, she was not received until the next September. The surgeon in charge obtained, however, at the time the following history: From childhood, and especially after beginning school, which was at an early age, the patient complained of "weak eyes." At first the trouble was not so much actual dimness of sight as inability of the eyes to bear prolonged use. At the close of a day at school, her eyes were fatigued and easily suffused. This condition gradually increased until there was perceptible failure of sight; and finally, two months previous to applying at the institution, the trouble culminated in actual blindness throughout a greater part of the field of vision in the left eye, and inability to read ordinary print with the right eye. The eyes had a vacant look, as if nothing was seen distinctly, while a convergent strabismus was noticeable in the left eye. The ophthalmoscope revealed a widespread pigmentary deposit throughout both retinae; the extent of deposit being about

\*The accompanying paper is but an abstract of that read by its accomplished author at the meeting of the Texas State Medical Association in April last.—D. W. Y.

equal in the two eyes. Large dark masses, composed of granular or "irregular-shaped spots," with prolongations following the course of the retinal vessels, occupied most of the face of each retina. Tension was not notably increased in either eye; but anæmia of the left retina was perceptible.

Although necessity of immediate attention to the diseased organs was urged by the surgeon in charge, the patient was not seen again for four or five months, when, in November, the left eye was found to have only qualitative perception of light from the temporal side; the right eye could distinguish No. L Snellen, at twelve feet from the temporal side, the field of vision being exceedingly narrow. Many of the retinal vessels of the left eye were apparently obliterated, while the retina of the right eye showed a decided paleness. Hemeralopia was now distinctly marked, and headache coming on at night prevented sleep. The headache was probably due, as Von Gräfe has pointed out, to the failing sight, and is produced by the intent endeavor of the patient still thoroughly to realize the visual impression.

Although things seemed so hopeless, it was determined to give the patient the benefit of an iridectomy in the right eye, removing at least one-fifth of the iris through an upward incision in the sclero-corneal junction. No pain or other trouble followed, and when, at the end of four days, the bandage was removed, the patient immediately declared she could see better by far with either eye than before the operation. Two months later, it was found that she could read ordinary print with her right eye; and at the expiration of three other months, she was able to read the finest print with that eye.

The left eye, before considered as entirely amaurotic, and beyond any relief whatever, had also gained somewhat, though very little. This little gain, however, coupled with a return of pain on that side, led to an iridectomy on the left eye; and while it effected no improvement in its sight, it gave permanent relief of the pain in the orbital region. The operation was not as thorough as was desired, the iris not being removed up to its ciliary attachment; yet the failure to increase vision was

due, no doubt, to atrophy of the optic nerve, as shown by the ophthalmoscope.

I need scarcely remark that the prognosis in this affection is extremely unfavorable, and no special treatment further than to protect the eyes from bright light and over-taxation is insisted on. The disease—retinitis pigmentosa—is evidently characterized by a decided torpor of the retina; the retinal vessels diminish in caliber, and many of the smaller branches are apparently obliterated. Schweigger has pointed out that this torpor of the retina “is due to the fact that on account of the diminution of the caliber of the arteries, an insufficient amount of blood is supplied to the retina;” and all writers agree that the pigmentation of the retina follows the contraction of the arteries, and is not the direct cause of blindness. The iridectomy was undertaken with the view of relieving this torpor by causing a determination of blood to the retina. No unusual tension was perceptible, which we know was the cardinal point with Von Gräfe when he operated for the relief of glaucoma.

The foregoing is the only case within the knowledge of the writer where retinitis pigmentosa has been treated by iridectomy, done as in incipient glaucoma, and more particularly where no abnormal tension could be discovered after the most careful examination.

I am aware that no single case can go far toward establishing anything; and in that now under consideration, it is possible, perhaps, that such improvement as occurred was a coincidence rather than a result. But the fact can not be questioned, that while previous to the iridectomy sight was very limited in one eye and wholly absent in the other, the patient expressed herself, immediately after the operation, as being improved, and came eventually to read ordinary print with the right eye, and experienced some, though very slight benefit to the sight of the left eye. Since no adequate explanation has yet been given of the good that follows iridectomy in glaucoma, I may be pardoned for offering none for the good done by the same operation performed in retinitis

pigmentosa, where, in the single case reported, ocular tension was not present.

The patient has a brother three years her junior, whose eyes seem to be going as hers went. The pigmentation in his appears to be equal to that observed in his sister's, though he still preserves good sight on first impression. A double iridectomy will be done for him with the hope of saving vision in both eyes.

WACO, TEXAS.

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## SYPHILITIC DISEASES OF THE THROAT.

BY RICHARD C. BRANDEIS, M. D.

These affections have always been considered as the most dangerous forms of constitutional syphilis, and cause the patient more distress, and the physician more anxiety, than almost any of the complications of this disease. They have generally been treated as identical diseases; but, for the sake of clearness, we will divide them into three classes, viz:

First. Simple syphilitic angina, which is the least dangerous, and which generally affects the parts at or about the isthmus of the fauces.

Second. Syphilitic pharyngitis.

Third. The ulcerated, perforating affections of the soft palate.

The first, or the simple syphilitic angina, is the most common form of the disease. It rarely attacks all the tissues included in the isthmus of the fauces, but more commonly one or the other parts, generally the tonsils, not so often the arch of the palate, appears as commonly on one side as the other, and not infrequently attacks both tonsils simultaneously. At certain times it makes its appearance very soon after the primary symptoms of syphilis are first detected, which I noticed to be a very frequent occurrence in the syphilitic wards



of Professors Zeissel and Sigmund, in the General Hospital of Vienna, during my stay there in the years 1871 and 1872. Occasionally I have observed the same thing since I have entered upon private practice.

On examination, we will find grayish white patches deposited on the congested mucous membrane, which, in the more marked cases, have the appearance of distinct exudations very similar to the appearance produced by a gentle cauterization of a mucous membrane. The affected parts are greatly congested, and this is particularly noticeable in case the tonsils are the seat of the disease. In the more severe cases, we observe a yellowish white exudation (membrane) situated on a very much congested portion of the isthmus, which gradually disappears from its border, and which will leave a slight superficial excoriation. I have never seen any true ulcerative action in any of this class of cases, which helps to distinguish it from the second and third divisions. Those ulcers, however, which are sometimes seen in this region may be considered as secondary to some pharyngeal or soft palatal trouble, or may even have extended upwards from the larynx.

I find in my case-book, June 3, 1875, the results of a post mortem examination of J— T—, aged forty-two years, who died from the effects of a fall, which gave rise to concussion of the brain: "There was seen a deep ulcer, the size of a silver half dollar, which extended upward from the root of the tongue, the right vallecule, affecting the tonsil, the anterior and posterior pillars of the fauces, and reaching up to the uvula, which was very œdematous. This ulcer was bounded by a pale border varying in width from one to three lines. In the region of the tonsil, there were only a few wart-like remains of that gland to be seen. The epiglottis was almost entirely destroyed, as were the arytenoid cartilages, some dense cicatrices being the only things to mark their former seat. The posterior wall of the pharynx was very much swollen and œdematous." In this case, I have no doubt that the origin of the ulcer was at the epiglottis, from which it spread in the direction above mentioned.

In very severe cases we sometimes find shallow ulcerations on the soft palate, on the palatal arches, and rarely on the tonsils, which, however, never grow any larger than when they made their first appearance. The base of these ulcers is covered with the yellowish exudation already spoken of. After they have been cured, their site is marked by slight excavations. I have seen this condition in but two instances. It will easily be understood why there is an almost entire absence of subjective symptoms when we consider that the sensitiveness of a mucous membrane diminishes in inverse ratio to the distance from the external cutaneous covering, and that the ulcerations are very superficial, and the inflammatory process very mild, in character. Only when the yellowish white exudation makes its appearance do the patients complain of burning and pressure in swallowing, which is probably due to the excoriation. The condylomata which make their appearance on the isthmus of the fauces, may be considered as a variety of these affections; they generally appear on the lower border of the soft palate and on the uvula, and at times must be removed with the scissors. We must not confound these with the *papules* and *plaques muqueuses* of Ricord, who regards the affection just treated of as one of the secondary symptoms of syphilis, and as a substitute of the exanthematic syphilides of the skin.

The second and more dangerous form of angina is the pharyngitis syphilitica. The seat of this disease is generally on one or the other, or both, sides of the pharynx, and more rarely in the middle of its posterior wall; sometimes it extends downward to the orifice of the œsophagus, behind the larynx, and only the experienced observer will be able to determine the nature of the case after learning all the subjective symptoms, and hearing all about the previous primary affection, and examining the hyperæmic condition of the posterior wall; only then will he be able to diagnose an ulcer of the pharynx, and recognize its callous borders. This form is generally limited to the mucous membrane, but occasionally extends to the submucous cellular tissue; and if the base of the tongue be

depressed and the patient yawns, and the soft palate is lifted up with a sound, an oval, serrated phagedænic ulcer will be seen on the posterior wall of the pharynx, very red and swollen. This is often covered by a layer of tough, yellowish white mucous, not very adherent and easily removed, when the ulcer will be easily recognized. The surrounding parts are generally, more or less, hyperæmic. The depth of the ulcer may vary from one-third to one-half a line, but appears deeper owing to the swelling of its margin. This form of pharyngitis always makes its appearance without presenting any subjective symptoms, but is soon followed by pricking and burning pains, which are always increased during deglutition; there is also dryness of the mouth, and on examination the ulcer already mentioned will be discovered. The callosity of the parts can readily be detected on touch, and the patient complains of pain if the part is pressed upon.

This disease is not alarming *per se*, but only on account of the danger of affecting the adjacent organs. Those ulcers which are situated low down are apt to extend to the larynx, and those situate near the soft palate are apt to extend to that part. If the disease is restricted to its original seat, it rarely affects the voice, which fact can readily be explained. Only the most superficial ulcerations, which do not require any treatment, disappear without leaving any traces behind, while the more marked ulcers leave a cellulo-fibrous cicatrix behind them, which sometimes occupies a considerable space, and may then produce a constriction of the pharynx, with all its disagreeable consequences. It is not very probable that this disease may, if it extends deeper, also affect the vertebra, as has been suggested. The probability is that, if there be both pharyngeal and vertebral disease, the latter was prior to the former affection.

Third. The most dangerous form of *angina syphilitica*, which is always a secondary symptom, is that which occurs on the soft palate, which destroys that part with great rapidity, and which gives rise to various deformities. Owing to its destructiveness, the attention and anxiety of the profession

has been aroused, and we are thus enabled to give an accurate account of the evil results which may follow. This disease is so insidious in its approaches that it not infrequently has advanced to a considerable extent before the patient has become aware of its presence; and it may, in the very shortest time, extend from a simple perforation of the soft palate to a total destruction of the same, as well as the inner and outer nasal tract, thus leaving behind it ineradicable deformities. In the majority of instances the nasal passages are affected, although it not infrequently occurs that the soft palate alone is the seat of the disease; and moreover it appears that the starting point of this affection is generally situate on the floor of the posterior nares, from whence it extends to the *septum narium*, and to the soft palate.

In case it first arises on the upper surface of the soft palate, the ulcer will not be as violent in its onslaught, and will more readily remain stationary than otherwise. The anterior surface of the palate is then highly congested, sometimes assuming a purplish tinge. The patients complain of severe pains, which are most intense during deglutition, and the posterior wall is hardened, ulcerated, and the least touch is very painful. The ulcer extends in area and depth very gradually, and sooner or later we notice an elevation of the epithelial layer of the anterior surface of the soft palate, through which numerous whitish yellow granules can be discovered; this elevation may become globular in shape. Within the next twenty-four hours this epithelium is destroyed, and a funnel-shaped ulcer is apparent, the smaller opening of which presents itself in the roof of the mouth. This soon increases in size, and assumes a very irregular and jagged shape. The margin is thickened and œdematous, and has the appearance of amyloid degeneration. If the circumscribed congestion does not diminish, we may rely upon it that its progress will be very rapid, and an energetic interference is very much needed. If the ulcer heals in this stage, which can be foretold if the congestion becomes less, then there will remain an oval perforation of the palate, which will ultimately heal up and cicatrize,

and leave no further unpleasant symptoms behind. In healing, if the ulcer had attained any considerable size, the uvula is drawn to one or the other side.

This disease often extends from the posterior palatal surface to the posterior wall of the pharynx. We then have, in addition to the symptoms just described, those already mentioned in connection with *pharyngitis syphilitica*. Both parts are swollen and inflamed; they approximate each other, and fibrous bands may extend from one to the other. The soft palate will thus become adherent to the pharynx after healing has set in, and the former arch of the palate and *isthmus faucium* will, after the destruction of the uvula, acquire a triangular form. If the ulcer has destroyed the greater part of the soft palate, it will be drawn further back, and will be converted into a dense, firm and unyielding bridge of cicatricial tissue. The communication between the nose and the mouth is thus cut off, and the patient will only be able to breathe when the mouth is wide open, if there be no perforation of the palate, or a small opening in the cicatrix, which latter is found in almost every instance.

The most alarming and hideous form of this disease is that in which the ulcerative process extends to the nasal mucous membrane and the septum of the nares. After the patient has been troubled for some length of time with a feeling of dryness in the nasal cavity, an offensive purulent discharge will suddenly make its appearance, which not only annoys the patient but those around as well. A sinking of the cartilaginous portion of the nose will soon manifest itself, so that we will have a deep furrow between the tip of the nose and the inferior border of the nasal bones; the continuity of the bridge of the nose is thus interrupted, which will enable us to differentiate between this and congenital deformities. This deformity, so commonly observed, seems to be due to the destruction of the cartilaginous or bony portions of the septum of the nose. although most patients deny that there was ever any separation or discharge of fragments of bone. We

must not place too much reliance on these statements, however, because without the knowledge of the patient little particles of ulcerated bone or cartilages are often hawked up; the septum of the nose is generally perforated, if not entirely gone. In only one instance do I remember that a patient showed me a small fragment of dead bone which he had removed from his nose, and it proved to be one of the turbinated bones, and was sufficient in itself to enable me to determine as to the syphilitic character of the disease. This form is the more marked if the disease extends to the floor of the nose, and terminates in perforation of the palate, as sometimes occurs. The basilar process of the occipital bone can sometimes be recognized if sufficient light be thrown through the perforation, and syphilitic patches can also be discerned. If this process proceeds unchecked the entire nose may be destroyed. But the further discussion of this subject would carry us beyond the legitimate limits of this paper.

In all the varieties of the ulcerative affections of the soft palate, we meet with the nasal voice, which varies in character with the severity of the attack, and is in itself a most lamentable result of this disease.

A peculiarity of the different forms described is their proneness to relapse. They manifest themselves under all methods of treatment, from simple antiphlogosis to the most thorough course of mercurialization. They appear to be most common after the use of the iodide of potassium, and then oftener if this be given in pill or solution than when used in substance. I have occasionally seen them after a course of the protoioduret of mercury.

LOUISVILLE, KY.

## A CASE OF INTESTINAL FISTULA—RECOVERY.

BY E. P. GILPIN, M. D.

William Jenkins, an intelligent mulatto, aged nineteen years, was admitted into the Indianapolis City Hospital, April 14, 1876, with the following history:

About a year ago he had been crushed between two logs, so as to break several ribs and force a splinter into the left side on a line with the ensiform cartilage. Being strong and healthy he made a good recovery, and soon resumed his work on the farm, although sometimes troubled by what he thought were pieces of splinter in his side. Ten days previous to admission he felt a "lump" in the left side of his abdomen, which was very painful; and three days after his abdomen was much swelled, accompanied by severe colicky pains, and on the following morning an abscess opened in the left iliac fossa, which he said discharged "blood, matter and filth." From that time until his admission to the hospital—one week—he had no passage by the rectum, but passed pus, gas and feces through the abdominal opening. He states that some physicians, in making an examination, passed a probe four or five inches into the bowel.

*Present Condition.*—Found an opening in the left iliac fossa, about three-fourths of an inch in diameter, from which feculent gas, pus and feces escaped. A little internal to the opening can be felt a moderately firm tumor, the size of a goose-egg, not sensitive to pressure. There is some deformity of the chest from the fractured ribs, and considerable enlargement of the liver. Pulse and temperature normal.

Intestinal fistula being diagnosed, he was ordered to be kept on his back, a compress was applied to the opening, and an enema of warm soap-suds administered, which was to be repeated every three hours until free evacuation occurred. After the second injection the bowels moved, and were kept open while he remained. Nutritious fluid diet was given, but



no solid food, and opiates sufficient to keep the patient comfortable.

On the second day the abdomen became very tympanitic and painful; the pulse and temperature, however, remained normal, and on removing the compress there was a free escape of fetid gas, followed by immediate relief. After this the compress was left off, and although there was frequent escape of gas, there was none of feces. At the end of a week there was no discharge of any kind, and the opening gradually grew smaller till May 8th, when he was discharged at his own request almost entirely well.

This case is reported for two reasons, first, because it is not a very common lesion; second, to show the happy result of a slight aiding of nature's efforts.

INDIANAPOLIS.

## SUCCESSFUL REMOVAL OF AN EXTRA-UTERINE FETUS.

BY E. T. EASLEY, M. D.

Frances Twitchell, aged thirty-four years; married, mother of three living children; duration of pregnancy, twenty-four months; position of child, directly across the front of the abdomen, head in right iliac fossa, back to pubic symphysis. Incision in the line of the linea alba, extending from an inch above the umbilicus to within an inch of the pubes. The cyst—dense, fibrous and tough—was not adherent in front, but had contracted extensive adhesions below. The child, of good size and well preserved, was adherent intimately at *all* points to the cyst. Liquor amnii absorbed; placenta nearly atrophied; the cord a mere string. The child was broken up and extracted piece by piece, a tedious dissection; and the cyst cavity sponged out and cleansed with a chlorinated wash.

The edges of the cyst were stitched to the abdominal wound by a fine uninterrupted suture, and the whole closed by deep interrupted sutures made to include the cyst walls. Free drainage was kept up from the lower end of the wound, and the cyst cavity constantly cleansed with antiseptic solutions, until it has gradually become obliterated by suppuration and granulation. I succeeded in excluding all exudation, hemorrhage or fluids, from the peritoneal cavity.

The patient is now in better health than since this pregnancy occurred. The operation was undertaken on account of the exhaustion and irritation of rapidly recurring attacks of pelvic and abdominal pain, and at the urgent desire of the patient and her friends. Doctors Watkins, Southall, Cross, Dibrell and Smith were present, and ably and judiciously assisted.

LITTLE ROCK, ARK.

[Dr. Easley is to be congratulated upon this successful operation. By a letter received from him this month (August), we learn that the patient remains in perfect health.

Dr. Parry, in his admirable monograph upon Extra-Uterine Pregnancy, observes that in case of the death of the fetus, gastrotomy is indicated if septicæmia, peritonitis, or exhaustion endangering life should supervene; it will be noticed that Dr. Easley had, therefore, excellent reasons for the operation. His method of operating and the after-treatment are alike to be commended.—*Editors of American Practitioner.*]

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## AN EXAMPLE OF THIRD DENTITION.

BY W. J. CARTER, M. D.

Mr. I. M., aged twenty-two years, came to my office July 3, 1876, to have the first upper molar tooth of the left side extracted, which he said had been aching severely for the

past two weeks. The tooth was drawn with great difficulty after the third trial, traction being made with all the power of both hands. The first effort slightly elevated one edge of the tooth, the second lifted it almost out of the socket, but the sequel proved it was not completely out, for the third pull was as hard and prolonged as the previous ones. The tooth came away entire, except a small longitudinal sliver of the outer prong which adhered to the alveolus, thus accounting for the great force required in the operation. The patient, who is perfectly reliable, informed me that this was his third set of teeth. The first set appeared when he was five or six years old, and was a full set of thirty-two teeth. The second set was also one of thirty-two teeth, and was shed when he was ten years old, following which the present set gradually made its appearance. Subsequently the young man's mother confirmed the above statements of her son. Three years previous to this time, Mr. M. informed me that a dentist in Indianapolis made three successive efforts to extract the corresponding tooth on the opposite side, which resulted in crushing the crown of the tooth.

Never before having met with a similar case, either in my practice or reading, I communicate it to the profession, thinking it may be of some interest physiologically, and of some practical value especially to the cross-roads portion of the profession, who are obliged to pull teeth as well as give physic.

MOUNT JACKSON, IND.

## Reviews.

**A Treatise on Surgery, its Principles and Practice.** By T. HOLMES, Surgeon to St. George's Hospital. With four hundred and eleven illustrations, chiefly by Dr. Westmacott. Philadelphia: Henry C. Lea. 1876. 8vo. 960 pp.

Mr. Holmes's treatise on surgery has by this time pretty well gone the rounds of the press, and has received even more than the amount of encomiums usually bestowed on works written by distinguished authors and issued by powerful publishers. Its style has been praised, its plan pronounced perfect, and as a text-book for students especially it has been declared the best in the language. Flaws in the work have been detected by an occasional reviewer, but these have been considered only such as are inseparable from human handiwork. We confess that we have been greatly puzzled by the general reception of this work by the press. Discounting the natural amiability of medical reviewers and the ease with which praise is bestowed, and all other circumstances which induce to make a favorable notice of a work so much more probable than an unfavorable one, we can scarcely account for the praise which has been bestowed on Mr. Holmes's book. The task of reviewing the work in the journals has, no doubt, in many instances, been committed to competent and independent surgeons, and that they should have found in it a tithe of what they declare they have found, is to us a matter of unqualified surprise.

Mr. Holmes says, in his preface, that he has attempted to represent the present condition of surgery, as it is practiced in his country, by a treatise which shall not be unworthy to rank with the other excellent text-books of the day. Certainly his ambition should have been satisfied in writing just

this sort of book. The ponderous and expensive volumes of his *System of Surgery*, filled though some of them are, in certain departments at least, with sawdust, have presented him to the profession as one supposed to be familiar with all of surgery. His treatise on the surgery of children, by odds Mr. Holmes's best performance, had stamped him as a specialist of excellent quality, and immediately gave him very high rank; and he could well afford to direct his last effort to that most important class of readers, the undergraduates of medicine. He says:

"It is not only the immense number of topics, and the endless details of all these, though necessarily some of these topics must be less familiar to any single surgeon, however wide his experience, than others are, and though it is hardly possible that some of the details should not escape the writer's attention, but added to this the necessary conditions of space press hardly upon the writer of a surgical work."

This is not very clear, but means, as the context shows, that nine hundred pages are not enough to give more than a brief abstract of the subjects which the author supposes to be indispensable in a text-book. And right here lies, in our opinion, Mr. Holmes's great mistake. His "*System*" is certainly boiled down in the work under notice, but the process has failed to produce a text-book in surgery as signally as would the compression of La Place's mechanics result in a suitable book for the use of beginners in mathematics. We agree with our author that the task is a difficult one. The difficulty, however, does not, as he seems to think, lie in the necessity for economizing space, but in curbing one's ambition to dip into all matters connected with subjects at once so numerous and so vast.

Mr. Holmes has made the common error of writing with the double object of reaching practitioners and students alike. Of his style, we are reluctantly obliged to admit that we have failed to detect that brilliancy with which he has been accredited. We have quoted above one of Mr. Holmes's worst sentences, it is true, but throughout the book, and notably

after the opening chapters, there abounds a looseness of expression calculated to awaken in the mind of the reader the idea that too much writing had overtaxed the powers and destroyed the enthusiasm of the author.

To one among many of Mr. Holmes's statements we must take decided exception. We can not agree that his treatise represents the present condition of surgery. We are sure that he labored to make it so; but that he failed can, we think, be shown in a very few words. Take, for example, the chapters on syphilis. These are certainly notably behind the times. Again, he would trust a fractured thigh in a child to a leather collar, which he says is better than the immovable apparatus, as it can be removed at pleasure. And later, he exhibits all the paraphernalia for the treatment of fractures generally, which seem bound to live until at least some great conflagration shall destroy the plates of the last century.

In the chapter on dislocations he introduces, it is true, Bigelow's methods, but *parenthetically* only; and then he pictures the pulleys of Cooper's days, which, if chloroform and manipulation are to go for anything, can but be regarded as useless.

Of hernia he says (page 618): "If the contents of the sac have, from any cause, become adherent to its interior, it ceases to be reducible, and is then called *irreducible* or *incarcerated*; and if besides this, the herniated viscera are constricted, so that the circulation of the contents of the intestines is suspended, it is said to be *strangulated*." We are unwilling to believe that Mr. Holmes regards "irreducible" and "incarcerated" as convertible terms, or that he thinks strangulated and incarcerated hernia the same.

But we will not pursue this part of our notice further. We have not the space, nor our readers the time, to go into details.

Mr. Holmes says he has not failed to refer to American and continental surgeons; so far as his information and space would allow. We are amiable enough to set down the small part which the labors of our countrymen are made to play in the work, rather to the want of space than to anything else.

In conclusion, we are constrained to say that we do not share Mr. Holmes's hopes in thinking his book deserving to take rank with some other excellent text-books in our schools. It has been said that comparisons are odious. But we can scarcely believe that our author will feel hurt when we say that among English books Mr. Bryant's *Surgery* is a better work for students—for students and practitioners alike; and that Mr. Erichsen's faultless volumes are in almost every single respect—in scope and in detail, in style and in finish—its superior. We even hope that we will not be thought sectional or deficient in the catholic spirit of the reviewer, when we venture the opinion, which we do only after a very careful comparison of the two books, that Ashhurst's *Surgery* is a very greatly better work than Mr. Holmes's. Indeed, with Ashhurst for the student and Erichsen for the practitioner, we see no opening yet for further lessons, certainly not for any contained in the treatise which it has been our ungracious task thus to notice.

Mr. Holmes should have been content with his great labor, the *System of Surgery*, and with his altogether admirable work on the *Surgical Treatment of Children's Diseases*. These two were as much as any one man could fairly be expected to do well in his day and generation.

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**Micro-Photographs in Histology, Normal and Pathological.** By CARL SEILER, M. D. In conjunction with J. GIBBONS HUNT, M. D., and JOSEPH G. RICHARDSON, M. D. Philadelphia: J. H. Coates & Co. Published monthly at 60 cents per number.

No doubt the above periodical will be a valuable aid to physicians in the study of microscopy, so important now in the department of medicine.

In the June number, among other photographs is one of a transverse section of bone, showing beautifully the Haversian canals, with the surrounding lacunæ and canaliculi. This shows how well and accurately the work is done.



## **Clinic of the Month.**

HYSTERICAL AFFECTIONS OF THE EYE.—Dr. George C. Harlan, Surgeon to Wills Hospital, Philadelphia, (Medical and Surgical Reporter, August 12,) thus speaks of these:

Though the term "hysterical" is a vague and indefinite one, which most of us would rather not be called upon to accurately define, still it has a conventional meaning, and, by common consent, is made to include a large class of cases in which there may be decided or even alarming symptoms without real disease. The expression is used here in its broadest sense, as it is not my intention to undertake a discussion of psychological pathology, but merely to call attention to a class of eye symptoms which I believe are not sufficiently dwelt upon in the text-books, and which I feel sure are very often misinterpreted in practice. I have more than once met with interesting, but rather mysterious, cases which had been reported in good faith by experienced surgeons, but which seemed to me to be clearly of this character; and, without doubt, a large proportion, if not all, of the magical cures of blindness by galvanism, that we occasionally hear of, may be referred to this class of cases. The hysterical affections of the eye that have come under my notice have appeared to me to include three kinds of patients:

First. Those who are the subjects of a kind of moral insanity, or at any rate of an insane perversity, who deliberately simulate a disease for months or years; who, in short, may be called hysterical malingerers; and who, to be cured, need only to be exposed.

Second. Those who really believe themselves to be affected as they profess to be, and are honestly anxious to be cured;

who are subjects of hysterical paralysis; and whom it would, perhaps, be unjust to accuse of acting a part.

Third. Those who are subject to irregular nervous action, to paralysis or spasm without assignable cause, but in whom there is no question of mental or moral complication.

Almost any derangement of vision may be counterfeited. A little girl of eight years complained that every object that she looked at seemed covered with diagonal white lines, the direction of which she indicated with her finger. As the ophthalmoscope revealed a normal fundus, a favorable prognosis was given. This was made more positive the next day, when the white lines changed to blue, and was justified by the early disappearance of the difficulty.

In the second class of cases we have more or less retinal anæsthesia, with anomalous and variable symptoms, changing, perhaps, at each examination.

In the third class of cases the parts affected have been the retina, the muscle of accommodation, the external muscles of the eyeball, and the elevator of the upper eyelid.

It is not very uncommon to meet with patients who have apparently perfect eyes and full acuity of vision, but who say that the test letters become blurred and unrecognizable after they have looked at them for a few seconds. That this is due to an exhaustion of the sensibility of the retina, which disables it from the sustained performance of its function, and not to an irregular action of the accommodation, is shown by the fact that it persists when the eye is fully under the effects of atropia. A partial failure of the accommodation may occur in nervous persons, either alone or in connection with other symptoms. Very satisfactory results may sometimes be obtained from the use of weak convex glasses, in the case of ladies who are quite young and entirely emmetropic. Exception may be taken to including the opposite condition of accommodative spasm among hysterical affections, because it usually occurs in connection with some error of refraction. In a very large proportion of cases, however, the subjects are delicate women, and the error of refraction is a very slight

departure from the normal standard, such as would not be felt by a person of fair average strength and nervous equilibrium. In other words, it is only the exciting cause, a strong predisposition existing in the temperament of the individual. These cases are of quite frequent occurrence in ophthalmic practice. Irregularity in the action of the external muscles of the eyeball, particularly insufficiency of the internal recti in convergence, is not uncommon in patients of this class, and frequently complicates their other ailments. A young married lady, a painfully hysterical subject, could scarcely use her eyes at all, though they were perfectly healthy and emmetropic, and the acuteness of vision was normal. The external muscles seemed, as it were, to have dissolved partnership, and each to act on its own account when she attempted to converge. Their irregular and variable action made anything like an accurate measurement of their force impossible.

The following is one of several cases in which there was occasional double vision from spasmodic action of one of the external muscles: Miss M., a little below par in general health, and of extremely nervous temperament, complained that frequently, without warning and without special exciting cause, as at the dinner table or at the opera, everything suddenly appeared double, and at the same time it was evident to her that she had lost control of the movements of one eye, which felt as if forcibly turned to one side. On closing the lids and pressing the ball for an instant, the symptoms would disappear. The acuteness of vision was normal, the balance of the external muscles for distant sight correct, and refraction nearly emmetropic. The correction of a hypermetropia of  $\frac{1}{8}$  did not prevent the recurrence of the annoyance.

There is one more affection to which I wish to call attention; it is of especial interest, because, though in this class of cases of little moment, it may be in others a symptom of very grave lesions. I refer to a temporary paresis of the elevator of the upper lid. There is a great difficulty, sometimes an impossibility, of opening the eyes when rousing from sleep. Some patients are able to raise the lid naturally after several

vigorous efforts of the will, while others are obliged to raise it with the fingers, and to rub or bathe it before acquiring control over its action. This occurs always on awakening, whether in the morning, during the night, or after a nap in the daytime, and is naturally the occasion of much uneasiness. I have notes of four such cases occurring in delicate ladies, and evidently of a hysterical character. Two recovered entirely, though not very quickly, under the use of tonics; a third lived at a distance, and I saw her only once; and the fourth is still under treatment. In the last the affection is of long standing, and is peculiar in the fact that for many months it was confined to one eye. The patient, about eighteen months ago, had difficulty in opening the left eye on awakening, the trouble lasting at that time for a few weeks only. About a year ago it commenced again in the same eye, has persisted since, and during the last few months has involved the right eye also, though to a less degree. Always when tired or weaker than usual she has the annoyance to a much greater extent; at times she is almost free from it. Her health is very feeble; she has had attacks of ague, etc., and is subject to functional palpitation of the heart and nervous prostration. There have never been any brain symptoms. The only example of this affection that I have seen in the case of a man, rather confirms the view of its hysterical character.

HEAT AND ITS INFLUENCE ON MORTALITY AT DIFFERENT AGES.—The weekly returns of the Registrar-General showed that the unseasonably moderate temperature which prevailed during June was very favorable to the public health. In London, for instance, the annual death-rate during the five weeks ending July 1st, averaged only 19.1 per thousand, whereas, under the influence of the seasonably hot weather which prevailed during the first three weeks of July, the death-rate successively rose to 19.8, 22.1, and 28.1 respectively. Thus, in the third week of July the mortality exceeded by forty-seven per cent. the average mortality in the five weeks of moderate temperature; in other words, six hundred more deaths were

registered in the third week of hot weather than the average number in the five weeks ending July 1st. There need be no hesitation in attributing this excessive mortality almost exclusively to the intense heat which prevailed during the first three weeks of July. If we exclude the deaths from diarrhœa, which are especially sensitive to temperature, the fatal cases of other zymotic diseases were remarkably stationary throughout the eight weeks under notice. It will be interesting, therefore, to note the effect of heat upon the deaths recorded in the different groups of ages adopted by the Registrar-General in his weekly returns.

It may be first noted that the deaths of persons aged under twenty years registered in London, in the five weeks ending July 1st, averaged 613, whereas they had increased to 1215 in the third week of July. This increase was equal to ninety-eight per cent. On the other hand, the deaths of persons aged upwards of twenty years averaged 665 in the five cool weeks, and were 663 in the third week of hot weather. The heat does not appear to have unfavorably affected the mortality of adults or elderly persons in the aggregate; the mortality between the ages of twenty and forty years, indeed, showed a decline of thirteen per cent., while that of persons aged upwards of forty years had only increased five per cent. Having ascertained that the whole of the increase of deaths due to heat occurred under twenty years of age, it will be useful to notice the excess in the subdivisions of this viceniad, which, in the Registrar-General's weekly returns, are three. Among young persons aged between five and twenty years the increase due to heat was eighteen per cent.; among children aged between one year and five it was twenty-three per cent.; while among infants under one year of age the increase was so great as 185 per cent. The deaths of infants under one year of age, which had averaged but 288 during the five cool weeks ending July 1st, rose to 822 in the week ending July 22d. Of the 600 deaths in the latter week which may be called the excess due to heat, no less than 534 were of infants under one year of age. Diarrhœa was the direct cause

of most of these deaths of infants, as the deaths from this disease, under one year of age, which had averaged but sixteen in the five cool weeks, increased to 386 in the week ending July 22d. The increase of deaths of infants from other diseases due to heat was, however, well marked, and was equal to sixty per cent. Seasonable weather, whether it be cold in winter or heat in summer, inevitably raises the death-rate. Its effect upon the mortality at different groups of ages is not, however, the same. Cold in winter is most fatal to elderly persons, and to adults who are more especially exposed to its influence. Intense summer heat, however, is only fatal to infants and in a less degree to children, while it exercises but slight effect upon the mortality of adults or elderly persons. The fatal effect of heat upon the death-rate of infants is, however, in great measure the natural result of ignorance and neglect of parents, who sacrifice their children to uncleanness, improper and unwholesome food, and carelessness as to the prompt treatment of diarrhœa. There is scarcely any form of mortality which can with greater justice be described as preventable than that due to infantile summer diarrhœa. This annual epidemic is a sad commentary upon the intelligence and social condition of our working classes. (*Lancet.*)

THE USE OF AROMATIC SULPHURIC ACID IN NECROSIS.—  
Dr. E. Cutter (Boston Medical and Surgical Journal) gives the following:

April 10, 1875, Dr. A., of Worcester, requested the writer to remove the necrosed alveolar process of his wife's sister. She was of middle age, pale, thin, weak, anxious, and worn. She had suffered much with her teeth. Her upper right middle, and two lateral incisors were found to be loose, and their lower edges hanging below the line of their fellows. There was a fungoid, spongy swelling over the front of the diseased process. When this was pressed, pus freely exuded from several openings, and also from a softish, elastic swelling as large as a hazel-nut, situated at the dome of the hard palate inside the mouth. The loosened teeth could be freely moved

in every direction with the thumb and fingers. The roots of the teeth distinctly grated against the sound alveolar process. There was a complete separation of the teeth and the bone. Dr. A. said that he had thought of using the aromatic sulphuric acid, but that the disease was so extensive and the separation so complete that he regarded it as useless to try to save the teeth in any way. It appeared to the consulter, however, while the surgical extirpation would be effective and justifiable, that if free incisions were made into the swollen and spongy gums there would be an evacuation of the contents of the dilated capillaries and abscesses; that a healthy action would be promoted by relieving this unnatural distention, and that the necrosed bone might be slowly removed by the stimulation of the aromatic sulphuric acid topically applied without destroying the teeth. It was thought that then the periosteum would lay down new bone in place of the old, and refasten the teeth in their old place. It was agreed to employ the following:

R Aromatic sulphuric acid, . . . . . ʒj  
Aquaë, . . . . . ʒj

By means of a half-ounce syringe supplied with a small ivory tip, one inch and a half long, and one-eighth inch in diameter, the acid solution was injected at first twice a day and afterwards once a day. About two drachms were used at each injection. The syringe tip was deeply buried into the soft tissues through one of the openings. Pus would freely exude from the other openings, even from that in the top of the mouth, after each injection. Tonics were administered; a diet of animal food and unbolted wheat was rigidly maintained.

From the outset of this departure a marked improvement in the soft tissues occurred. But the teeth remained loose and dangling, and Dr. A. thought their recovery doubtful. It was resuggested that it would be an easy thing to remove them at any time if they did not reset, but that the process of replacing old with new bone was of necessity a slow one.

In about forty days the outer incisor became solidly fixed in its old site. Then the next incisor also tightened. The



middle incisor tightened slowly. In November following it could be very slightly moved, but its edge was a little below the line of the other teeth. The other two incisors were as stiff as they ever were. A few spiculæ of bone were removed from the front of the alveolar process during the period of the treatment. In the meantime the general health of the patient improved greatly. She gained in weight, color and strength. At the present time (July, 1876) she is entirely recovered.

We think it is reasonable to connect the result in this case with the means employed, the acid, the tonics, and the food.

Dr. Atkinson, of New York, has reported some remarkable instances of cure of necrosis by this agent used in its full strength, it is said. It hastens the disintegrating and separating processes, and at the same time destroys the germs of parasitic micrographic growths in the dead and dying bone. According to Dr. Atkinson, it does not act unhealthily upon sound tissues whose vital connections are unimpaired. No substances stand higher than the mineral acids as antiseptics and destroyers of bacteria, amœbæ, and vegetations of animal secretions. Were it not for their caustic effects, they would long ago have supplanted carbolic acid.

#### MR. WALTER REID'S METHOD OF TREATING ANEURISM.—

Last month we gave a notice of this method. In the *Lancet* of August 5th, we find a communication from Mr. Reid, in which he mentions the death of the patient, and gives the post mortem examination:

The cause of death, as ascertained by post mortem examination, was hypertrophy of the heart, associated with bronchitis, effusion into both pleuræ, and cirrhosis of the liver. There was no internal aneurism, and the coats of the large vessels appeared to be sound.

The remains of the aneurism in the left popliteal space were removed and examined. The tumor, when cleared, was of the size and general form of a small walnut. The artery was occluded for two and a half inches of its course by fibrous tissue, and from the lower half of this portion the aneurism

sprang. The popliteal vein was pervious throughout. Numerous collateral branches could be seen running into the artery above and below the occluded portion. On making a section of the tumor in the long direction and from the side opposite the artery towards the vessel itself, the following appearances presented themselves: The sac was well defined, being thicker where it joined the artery than elsewhere. The center and also that portion of the cavity adjacent to the vessel were occupied by an amorphous, non-laminated, coffee-colored substance, of the consistence of cheese, which showed no signs of organization or of vascular connection with the surrounding parts. That portion of the circumference of the cavity of the aneurism opposite its mouth was occupied by several layers of laminated fibrine. Some of these were partially separated from the others and approximated towards the center, the interspace thus caused being filled by the amorphous substance, which, however, was of a looser character than that already described.

The amorphous, non-laminated substance could be nothing else than the remains of an ordinary blood coagulum, and, since the aneurism was originally the size of a hen's egg and finally that of a small walnut, it could only have represented a small proportion of the original bulk of the clot. The fibrinated laminæ were probably due to the attempts which I made at cure by compression, and the displacement of some of these resulted from the contraction of the sac upon them subsequent to the cure. I think so, because the coagulum in the interspace was soft and loose, and seemed to represent a portion of the more fluid parts of the larger mass which had been expressed from it, likewise by the contraction of the walls of the sac.

In my pamphlet, which was written a month previous to the death of the patient, I attempted to show that the aneurism was cured by the rapid coagulation or death of the blood consequent upon its complete stagnation in the sac. I think that this explanation is well borne out, not only by a consideration of the phenomena of cure, but also by the post mortem appear-

ances. I beg here to acknowledge the numerous communications that have reached me from surgeons, generally expressing an intention to try this method on the first opportunity. I am accordingly in hopes that it will ere long be determined as to whether the success which may follow its application shall only be looked upon as a rarity, or whether it may be destined to revolutionize the whole surgical treatment of aneurism, and enable us to treat the disease in certain situations with the regularity and precision of a physical experiment.

**HYPOPHOSPHITES OF LIME AND SODA IN PHTHISIS.**—Dr. M. Charteris (*Lancet*, July 29), after giving the history of some cases in which the hypophosphites were administered, says:

These cases are faithful examples of the use of the hypophosphites in phthisis, either in the form of lime or soda. That the medicine is not inert, its power of checking night-sweats evidences, and also its influence in giving tone to the system, if by this is meant increase of appetite and general cheerfulness. Without expressing a definite view on the subject, I have been somewhat forced to the conclusion that if the hypophosphites did no good, they certainly did harm, and in some measure hastened a final issue by increased fever, as indicated by a higher temperature. While acknowledging the benefit derived from their use, as testified to by patients themselves and by competent witnesses, I am of opinion that they should by no means be used indiscriminately, and that when given their effect should be carefully watched by daily thermometric observation.

In further alluding to the difference of temperature in the sides affected in phthisis, the following results have been noted: In one extreme case, following an attack of pleurisy of the left lung, and where the right was unaffected, the average increase of the evening temperature for a month was  $.96^{\circ}$ , or very nearly a degree. In another, where the right lung appeared alone affected at the apex, the result of ten observations showed a difference of  $.38^{\circ}$  in the morning and  $.40^{\circ}$  in the evening. In another case, at present in the hospital, and

where there are absolutely no other physical signs of phthisis except weakness and emaciation, the following facts have been recorded as the result of temperatures taken morning and evening, and extending over a period of ten days: Evening, left side, average  $101.86^{\circ}$ ; right side,  $101.56^{\circ}$ . Morning, left side,  $100.36^{\circ}$ ; right side,  $99.96^{\circ}$ . Health certainly gives no variation like this, and no other disease simulates phthisis so much as enteric fever. A case of enteric fever was admitted into my wards on the same day as the one last mentioned, and the temperature was taken carefully on both sides, with the result of finding no appreciable difference, the average being on both sides  $99.4^{\circ}$  in the morning and  $101.2^{\circ}$  in the evening, and, as convalescence was reached,  $98.2^{\circ}$  in the morning and  $99.6^{\circ}$  in the evening.

#### PLEURAL EXUDATION EMPTIED THROUGH THE MOUTH.—

The following case is communicated by Dr. Frommüller from the hospital in Fürth: John S., aged twenty-one years, belt-maker, has suffered a long time from a severe cough, with profuse expectoration, general emaciation, hectic fever and night-sweats. He observed one evening, while he was stooping over to pull off his boots, that on account of very limited respiration and from an impulsive cough, a very large quantity of a clear, yellowish fluid gushed out of the mouth. Some days afterwards, on the 19th of November, 1875, he entered our hospital. Physical examination disclosed far advanced tubercle of the lungs, especially at the right upper lobe, and a rather extensive exudation into the right pleural sack. On more than one occasion the experiment of stooping over being repeated by him, he discharged every time a moderate quantity of a clear, yellowish-green fluid. This fluid much resembled the white of an egg, with all the properties of an exudation from the lung covering. On the sixteenth day after his admission the patient died. At the autopsy there was found an exudation into the right pleura; the right lung was suppurated greatly, and broken through with cavities. The largest of these cavities—about the cir-

cumference of a chestnut—was found in the middle lobe, in the nearest proximity to the pleura, where it communicated with the pleural exudation. On the other side of this cavity a communication had taken place with a large bronchus at its point of bifurcation. The mucous membrane of the stomach and intestines was pale but normal: there was chronic nephritis; spleen and liver were normal. (*Memorabil.*, July, 1876.)

LANGENBECK'S SURGICAL TREATMENT OF HERNIA.—In the *Memorabil.*, July, there is a communication upon M. Langenbeck's treatment of hernia. He operates without opening the sac, is careful in breaking up all adhesions, and has lost only three cases in fifty-nine operations.

For the radical cure of hernia, his method of operating gives excellent results. A flap of skin as thick as possible, and corresponding in length and width to the hernial opening, is made from the abdomen. For an inguinal hernia, the base of the flap extends from the symphysis pubis to the pubic tubercle, and the flap extends upward and outward an inch and a half or two inches; for a femoral hernia, the flap is made from the *fossa ovalis*, and is about half as long; for an umbilical hernia, from any direction except near the suspensory ligament of the liver, or *ligamentum teres*. After preparing the flap, the finger is introduced through the canal or opening, to make room for it; then the flap is introduced either by the finger or an instrument; it is not twisted, but only laid deeper in its natural position in the abdominal wall. The external wound is closed by twisted sutures, and cold applications made for only a few hours.

HOT WATER IN UTERINE THERAPEUTICS.—Dr. Hyatt (Virginia Medical Monthly, August) has an excellent article on this subject. Dr. Hyatt recommends hot water in various uterine diseases, as originally suggested by Dr. Emmet, and in pelvi-peritonitis and pelvi-cellulitis. He has also had success with it in metrorrhagia. In this last application, however, Dr. Hyatt has been anticipated by Trousseau.

**SALICYLIC ACID AS AN ANTISEPTIC.\***—As lately Professor Salkowski, of Berlin, did not agree with the results of the experiments by Kolbe, by which the antiseptic qualities of salicylic acid seemed to be established, but questioned them, and referred to benzoic acid as giving better results (*Berliner Klinische Wochenschrift*, 1875, No. XXII,) it shall not be the object of this article to controvert the theories of the former, but simply to gather together the results of previous investigations and experiments with the salicylic acid, and make a rapid review of Kolbe's investigations to determine their weight and character. Farther experiments must be deferred to determine which of the acids shall gain preference, both technically and in operative employment. I have found such satisfactory results from the salicylic acid in my specialty that I can not believe it will be displaced by the benzoic.

Salkowski brings up the high price of salicylic acid as an objection to its use; but since this has been so much reduced by Kolbe's methods of production, it has become a small item of difference. In the conclusion of Salkowski's article, he says that Kolbe's services should not be underrated, because his investigations have, if nothing more, drawn attention to the aromatic combinations. It must be said, however, that these investigations were made with a perfect knowledge of the character and properties of the benzoic acid. There can be no doubt but that salicylic acid—the medical treasure introduced by Kolbe, which is now the subject of so much discussion, and the usefulness of which is confirmed by Professor Theirsch—is drawing more and more attention, not only from the professionally educated part of the community, but also the producing classes are following the development of its properties and virtues with the deepest interest. The undoubted confirmation of its antiseptic properties points to early and important changes in the production of many of the necessities of life. Especially we may mention the conservation of wines, beer, and meats; also the management of

\* From the *Vierteljahrsschrift für Zahnheilkunde*, page 20, 1876. By Prof. H. Humm. Translated from the German by Dr. G. V. Black, Jacksonville, Ill.

wounds and suppurating surfaces with salicylic acid in substance or in solution, and the treatment of three epidemics which depend on fungoid growths, both in man and beast.

The knowledge and the production of salicylic acid, is not of recent date. It was first obtained only from salicin, which was discovered by Regatelle in 1826, but earlier by Fontana, an apothecary in Laziza, near Verona, in 1825. It was obtained from *salix pentandria* and *salix fragilis*. According to Lasche, salicin can also be obtained from other varieties of *salix*, as *salix purpuria*, *salix helix*, *salix lambertina*, and not only from the leaves but from the female flowers and the young twigs.

Salicin crystallizes in small, four-sided, brilliant milk-white prisms, or small white scales. It is of an intense bitter and astringent taste, is not changed in the air, dissolves readily in water or alcohol, but is not soluble in ether and the essential oils; melts a few degrees above  $100^{\circ}$  C., and is decomposed by a few degrees higher heat. It is not an alkaloid, but in its chemical relations is indifferent. By sulphuric acid it is changed into a dark brown mass (retilin), and according to Marchand, its formula is C 28, H 38, O 15. (Journal for Practical Chemistry, 1842, Vol. XXVI, p. 385.)

According to Piria, salicyl is the radical of salicin. With hydrogen it forms a hydrate of salicyl, which is a reddish oil, readily soluble in alcohol and ether, and behaves with alkalis and metaloids like the hydrogen acids. When salicyl is treated with melted potassium, the salicylic acid is formed.

It is this formerly known, but almost unnoticed acid, which has of late attracted such universal attention, not merely from the chemist but also from the physician and artisan. For this we must thank Kolbe, Theirsch, Newbauer, and others, for their very interesting and complete investigations; especially the first, who, in company with Lanteman in the year 1860, in a course of investigations of salicylic acid as a derivative, discovered the salyl acid, which he described as isomeric with benzoic acid. Soon afterward Kerkule pointed out the possibility that there were other acids isomeric with the benzoic,



which he based upon an hypothesis of his own in regard to the chemical constitution of benzoyl. His conclusions were taken up by a number of chemists, and it was held that the finding of one acid isomeric with the benzoic threw the whole fabric of the chemical constitution of the aromatic combinations together (in one isomeric line), and they were therefore unstable. A correct decision as to whether salicylic acid is identical with the benzoic, or isomeric with it, is of the utmost importance. This has induced Kolbe to again take up the work formerly done by himself and Lanteman, especially as the argument brought forward by Richenbach and Beilstein seems not to be so conclusive as might at first be supposed. In the meantime it was no light task for him to more clearly prove his opinions of 1860 and defeat Kerkule's argument. This was largely the fault of circumstances, since it was exceedingly difficult to bring together the necessary materials for the required amount of salicylic acid without too great a cost. This difficulty resulted in directing him to the finding of a cheaper mode of producing the acid. The gaultheria oil contained but a very small per cent. of salicylic acid, and seems poorer latterly than formerly, and is therefore too costly for the preparation of very many pounds. Kolbe was, therefore, led to reinvestigate the plan previously described by himself and Lanteman, by which salicylic acid was prepared artificially from phenol and carbonic acid in the presence of sodium, to determine whether or not it could be simplified or perfected to such an extent that a cheaper acid could be produced. He succeeded in producing by this means a very considerable quantity of the salicylic acid, which, at the present price of sodium, would not be dearer than that produced from gaultheria oil.

During these experiments, Kolbe was surprised to find that by apparently the same manipulations the amount of salicylic acid obtained was sometimes quite large, sometimes very small. In finding the key to this mystery, he was led to a new plan of production. Upon dissolving sodium in hot phenol, in a current of dry carbonic acid, salicylic acid is

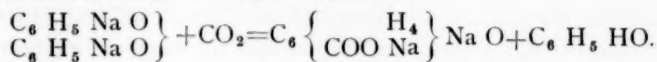
formed, and with it always, more or less, carbonate of soda and phenate of soda. Kolbe now found that the richer the production of salicylic acid, the less of the compounds above mentioned were found. He afterward observed that a product which was especially rich in phenate of soda, and poor in salicylate of soda, produced a large amount of salicylic acid when treated anew with carbonic acid under a higher heat. Upon this discovery, he determined to again try the plan of producing salicylic acid from phenate of soda and carbonic acid, which had formerly yielded but a very trifling amount. After many experiments he succeeded in determining the conditions, and so completing and simplifying this process, that from phenate of soda and carbonic acid, the theoretically reckoned amount of salicylic acid could be obtained without difficulty, and at small cost, which was done in an iron retort, prepared for the purpose, in twelve hours, without much attention during the process, producing eight to ten pounds of salicylic acid. A saturated solution of phenol and soda is evaporated in a shallow iron vessel, and the resulting mass—phenate of soda—is then dried over a light heat, with continued stirring, and afterward rubbed until it is reduced to a dust. This is then (when large amounts are used) put into an iron retort, and slowly heated in an oil, metal or air-bath, until it has reached about  $100^{\circ}\text{C}.$ ,\* then a light current of carbonic acid is passed through it. The temperature is gradually raised, reaching  $180^{\circ}\text{C}.$  some hours afterward. Some time after the introduction of the carbonic acid phenol begins to distill over; later in larger quantities. At last the temperature is raised to  $200^{\circ}\text{C}.$ ,  $250^{\circ}\text{C}.$ , and the operation is ended. When under this temperature, with the continued passage of the current of carbonic acid, no more phenol passes over. In regard to the process of the formation of salicylic acid, Kolbe says he had at first supposed that one molecule of carbonic acid inserted itself into one

\* Degrees of the Centigrade thermometer may be reduced to Fahrenheit thus,  
 $100^{\circ}\text{C} \times 9 \div 5 + 32 = 212.$

molecule of phenate of soda, and so formed one molecule of salicylic acid, according to the following formula:



But I now perceive that the process runs otherwise, which I could not before understand. That by the influence of carbonic acid on strongly heated phenate of soda, a large quantity of quick crystallizing phenol distills away from the phenate of soda, which, as I have lately determined, is just one-half of the phenol used in preparing the phenate of soda. The contents of the retort, after the reaction is ended, *i. e.*, after the continued passage of the current of carbonic acid until the heat has attained 250 C. as described, is by a good result-  
ing operation of a grayish white color, it is salicylate of soda, the so-called basic. The following formula expresses the chemical changes during the operation:

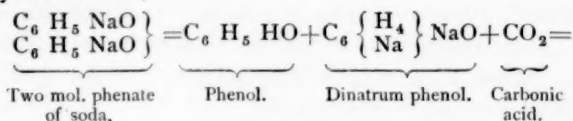


Two mol. phenate  
of soda.

Salicylate with two equiv.  
of sodium.

Phenol.

With two molecules of phenate of soda in the presence of carbonic acid, one equivalent of hydrogen is displaced by soda, which results in the formation of phenol and a phenate of soda containing a double portion of sodium, which last immediately combines with the carbonic acid, producing the salicylate of soda, thus:

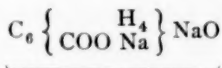


Two mol. phenate  
of soda,

Phenol.

Dinatrium phenol.

Carbonic  
acid.



Salicylate of soda with two equivalents of sodium.

This last combination bears a temperature of 300° C., without decomposition; dissolves readily in water with a dark brown color. On the addition of hydrochloric acid the sali-

cylic acid is precipitated in the form of a thick curd. This is dried on a linen cloth, or the mother liquor pressed out as well as possible. Through recrystallization and other methods of purification, the salicylic acid may be obtained perfectly pure. If it is wished that it be obtained chemically pure and snow-white, it is dissolved in methyl alcohol or ethyl alcohol, which is removed by heating in a pure solution of caustic soda, precipitating with hydrochloric acid and thoroughly washing the precipitate.

The salicylic acid prepared in this way is isomeric with that prepared from the willow bark. When not rectified, its color is a light yellow from a small portion of phenol. It is in powder, crystalline, or in needle-like crystals. Slightly soluble in cold water, more largely soluble in warm water, melts at about 60° C., and by a slight elevation of this temperature is decomposed into phenol and carbonic acid. For the reason that salicylic acid may be formed from carbolic acid and carbonic acid, and is also decomposed into the same compounds by light heat, Professor Kolbe came to the conclusion that it would, like the carbolic acid, prevent decomposition, or possessed antiseptic properties. The conclusion was verified by experiments by himself and Professor Theirsch. Amygdaline was dissolved in water, and a small percentage of salicylic acid added and well mixed, and an emulsion of sweet almonds added; after a quarter of an hour there was not the slightest smell. In a similar way a number of experiments were tried with small additions of salicylic acid, and there was no smell of the bitter almonds for several hours, and by the addition of a little greater proportion of the salicylic acid no smell was detected for twenty-four hours.

Ground mustard in lukewarm water soon gives out the smell of mustard-oil, but fails to do so when a slight amount of salicylic acid is added. A small portion of salicylic acid, added to a solution of sugar, prevented yeast from working. A solution of sugar already in the process of fermentation was stopped by a small amount of the acid.

One thousand grammes\* of beer, to which 0.8 to 1.0 grammes of salicylic acid was added, showed no sign of spoiling after fourteen days' exposure; also less than the one-thousandth part of salicylic acid is sufficient to prevent beer from spoiling for a long time. The small amount of 0.04 per cent. of salicylic acid added to fresh milk, is sufficient to prevent its souring at a temperature of 118° C. Fresh meat, with salicylic acid rubbed upon it, does not spoil for weeks in the open air. Fresh eggs, that were soaked for an hour in a water solution of the acid, lost nothing in taste or smell in four months, and could not be told from fresh eggs.

The salicylic acid, by common room temperature, is dissolved by distilled water in the proportion of one to three hundred. This solution is called salicyl water† by Professor Theirsch, and possesses remarkable antiseptic properties. Urine to which the acid is added in this proportion, or in larger quantity, does not decompose, and still contains uric acid after nine months. Blood and pus are kept in the same way. A large amount of albuminates are precipitated from the serum of pus by salicylic acid, as is also done by one per cent. solution of carbolic acid. Fresh and granulating wounds are in no wise injured, nor is any inflammation caused by washing with salicyl water. By long washing of wounds with salicylic acid, it may be detected in the urine. Instead of washing with salicyl water, Professor Theirsch advises the application of the acid in substance to suppurating wounds or mortifying parts to the thickness of 0.2 to 0.5 centimeters, for the reason that in washing with the solution the effect will not reach to sufficient depth. After many and continued experiments, Professor Theirsch is of the opinion that the salicylic acid possesses all the virtues of carbolic acid without its objectionable features.

Newbauer and Kolbe have made further experiments for determining the antiseptic properties, which are of importance to producers of wine and beer. Newbauer tried the following

\* One gramme equals 15.444 grains.

† Salicyl wasser.

experiments with chemically pure salicylic acid: Fifty C. C.\* of clear filtered unfermented wine, which had been heated to 65° C., was mixed with salicylic acid, and a small amount of wine ferment added to it. The same quantity of the same wine was mixed with a like quantity of wine ferment without the salicylic acid, for comparison. In the last, fermentation proceeded as soon as the ferment spores had begun to increase—in a few days; while in all experiments there was no increase of the ferment spores, and absolutely no fermentation in that to which the salicylic acid had been added. In order to determine the amount of salicylic acid required to destroy or prevent the operation of a certain amount of wine ferment, the following line of experiments (beginning on the morning of November 17th) were tried. To each one thousand liters† of unfermented wine, the following quantities of salicylic acid were mixed; first, none; second 12, 24, 36, 48, 60, 72 and 96 grammes. Each of these received one C. C. of active wine ferment, which was found to contain 0.0049 grammes of dried ferment cells. The ferment used was *sacchromyces ellipsoideus*, with a small amount of *sacchromyces apiculatus*, fresh grown, and entirely free from other fungous seeds. On the morning of the 19th (two days), the wine having no salicylic acid (No. 1) was in active fermentation; No. 2 also showed a weak fermentation, not nearly so active as No. 1, but apparently normal; Nos. 3 and 4 first showed signs of fermentation on the 20th; No. 5 showed the first signs of fermentation on the afternoon of the 23d, and on the 25th the fermentation was proceeding very feebly; No. 6 showed the first gas bubble on the 27th, and a very slow fermentation followed; No. 7 showed the first gas bubble on the 2d of December; No. 8 was perfectly clear at the end of four weeks, the ferment cells which had been added had sunk to the bottom, no growth had taken place, no gas bubble had been formed; not the slightest trace of fermentation could be discovered, although the amount of ferment had been ample.

\* Thirty-one cubic centimeters equals one ounce.

† One liter equals 2.1135 pints.

[TO BE CONTINUED.]

## Notes and Queries.

STOLTZ ON MENSTRUATION.—The ovarian theory of menstruation having recently been ably controverted, we opened the last issued volume of the *Nouveau Dictionnaire de Médecine et de Chirurgie Pratiques*, which has just been received, anxious to know whether the most recent French authority would discredit the researches and reject the conclusions of Negrier, Coste and Raciborski. Stoltz is the author of the article on *Menstruation* in this volume, the twenty-second of the series; and we wish those who have been in so much haste to follow a few wandering German lights, or from occasional exceptional cases, such as conception without menstruation, and periodical hemorrhage from the womb after the removal of the ovaries, have been in haste to assert as a general truth that ovulation and the monthly flow are independent phenomena, would carefully read Stoltz's views. He states that the theory of periodic ovulation to-day deserves the most reliance, since it rests upon numerous observations, is completely in accordance with observations made in animals, and finally is the simplest and easiest of comprehension. Ovulation is not only *spontaneous*, that is independent of sexual excitement, but still more, is subject to the law of periodicity. Menstruation is the sign of ovulation, at the same time that it is a consequence of ovarian activity. The disposition to procreation is continuous in the male, while fecundity is intermittent in the female, alike in the human race and in animals; though certain German writers have sought to make women differ from other females in regard to reproductive power.



DISCUSSION UPON THE PUERPERAL SOUFFLE.—In the Paris Academy of Medicine there has recently been quite an interesting discussion upon a souffle, first pointed out by Kergaradec in 1822, and denominated by him *placental*, a title which it still unfortunately holds with some obstetricians. The discussion grew out of a paper by M. Glénard, of Lyons, who presented a new explanation of the souffle, attributing it to pressure upon the epigastric artery, and denominated it epigastric. But Glénard has had to acknowledge himself mistaken, and now deserts the epigastric, carrying his theory to an artery connecting the ovarian and uterine artery on each side, and baptized by him the anastomotic; but it is doubtful whether the theory can live more securely in its new retreat than it did in its first home.

The objections to the *placental* theory are that the souffle persists after the delivery of the placenta, does not cease after section of the umbilical cord, there is no important branch of the umbilical artery specially designed for the nutrition of the placenta; and, finally, the souffle is isochronous with the fetal heart.

The epigastric and the placental theories being rejected, there remain the iliac and the uterine theories. Bouilland is the author of the iliac theory, and ably sustained it; while the uterine theory—that which meets with most general acceptance—originated with Dubois, and has been firmly supported by Depaul.

AN ENCYSTED OR ADHERENT VESICAL CALCULUS.—Dr. W. H. Park, of Tyler, Texas, encountered an adherent calculus in one of his late lithotomies. The patient, a male, was aged twenty-five years. On reaching the bladder the operator found two calculi, one small and free, the other very large, encysted or adherent to the bladder high up and behind the pubes, and so far away that neither the finger nor scoop could be used in detaching it. It was after much difficulty seized with the forceps, crushed and removed in fragments. The

bladder was largely encrusted with phosphatic matter around the site of the stone; and the removal of these crusts with the finger and scoop, added to the time occupied in extracting the larger calculus, made the operation extremely tedious, notwithstanding which, however, the patient made a quick and good recovery.

THE CRITICISM OF DR. BARTHOLOW'S LECTURE BY DR. CARSON AGAIN.—The last number of the American Practitioner (August) contains my rejoinder to the criticism of Dr. Carson, and his reply. I might comment on the singularity of the rejoinder and the reply appearing in the same issue; but I am pleased that the papers should stand side by side. I am quite content to leave the questions thus far discussed to the judgment of all unbiassed readers. Your reviewer has, however, brought forward a new question entirely. He quotes from my recently published Treatise on Materia Medica and Therapeutics, in order to make it appear that I contradict myself on the subject of the action of digitalis. You must allow, I think, that he has exceeded his privilege as a reviewer of my lecture, and now makes issues that wear a personal aspect. I am glad that he has thus more decidedly even than before shown the *animus* of his criticism.

I have now the serious accusation to make against Dr. Carson, that he quotes me wrongly, and in a way that is perfectly abominable. I formally declare that he has falsified the text of my work; and I demand now, in the presence of all your readers, that he confess this shameless license. That there may be no doubt, I quote the passage and indicate the word in italics, which he has substituted:

"That digitalis has any power to prevent the *deputation* of fibrinous material, to prevent or check the migration of the white corpuscles, or to arrest the multiplication of the cellular elements of inflamed parts, seems to the author highly improbable." (*A Practical Treatise on Materia Medica and Therapeutics*: New York, D. Appleton & Co., 1876, p. 275.)

If any one will take the trouble to refer to the volume and page as above given, he will find that I say *deposition*, which gives a wholly different meaning.

The opposition of opinion which Dr. Carson affects to discover in my views as expressed in my lecture and in my treatise, exists only in his own mind. In my lecture (p. 14), to illustrate the antagonism in the action of digitalis and the morbid process in pneumonia, I place the following in juxtaposition:

## DIGITALIS.

Exudation checked or prevented by the  
heightened tonicity of the vessels.

## PNEUMONIA.

Exudation of fibrinous material.  
Migration of white blood corpuscles.

In my lecture I state that the heightened tonicity of the vessels may, by checking exudation, and the migration of the white blood corpuscles, "limit the area of the inflammatory action." I show in my work that digitalis can hardly affect the power of amœbiform movements possessed by white blood corpuscles, or prevent the multiplication of the cellular elements of inflamed parts. This is a power distinctly possessed by quinia. The same result—as respects fibrinous exudation, or the passage through the vessel walls, of leucocytes—may be, in part at least, secured by the property which digitalis has of raising the tonicity of the vessels. The same idea precisely is expressed in my work in the sentence immediately succeeding the one quoted by Dr. Carson:

"That it [digitalis] may be useful to combat some of the symptoms—high temperature, ischæmia of the arterial system from pulmonary obstruction, and low tension of the vessels—may be well admitted." (l. c., p. 275.)

I, of course, am not to blame, if Dr. Carson is unable to appreciate these elementary truths. A reviewer should have a little common sense as well as common honesty.

Dr. W. C. is like a certain hefty medical writer in our city, who is constantly discovering fallacies in physical diagnosis, when he is merely discovering his own ignorance.

*Cincinnati, August 22.*

ROBERTS BARTHOLOW.

THE POPE'S SECRET SURGEON.—The death of Dr. Vincenzo Sartori left vacant the post of "secret surgeon" to the Pope, and that has just been filled up by the appointment of Dr. Ceccarelli, who has for some years acted as surgeon extraordinary. For his introduction to the Vatican Dr. Ceccarelli was indebted to Monsignor de Mérode, whose fractured leg he skillfully reduced, and who, out of gratitude, got the Pope to consult him, although His Holiness had already two competent medical advisers in Drs. Viale-Prelà and Constantini. Regretting as he does the death of Sartori, who was nearly contemporary with himself, and whose sagacious judgment he often had recourse to in other matters besides his bodily infirmities, the Pope has had good ground to be satisfied with his new "secret surgeon." His health was never better than at present. The same restorative treatment is observed. The strong capon-soup, followed by a glass of "the best of Rhenish wine" (sometimes alternating with Romanée, Conti, or Cyprus of the Commandery,) sustains his strength. In the prevalent heat he avoids the gardens of the Vatican, and takes his daily walks in the spacious and equably ventilated halls of the palace itself. He visits regularly the "Gallery of the Geographical Maps," where he traces the movements of the belligerents at the seat of war, in which he takes a lively interest. He surprised his attendants the other day by mounting the stairs that lead to the gallery in question without the aid of the staff, which is generally his support and invariably his companion. (*Lancet*.)

THE CONVENTION OF MEDICAL COLLEGES.—Our able cotemporary, the *Atlanta Medical and Surgical Journal*, says:

"Let every school send one or more delegates to the next convention, and let them go prepared to make concessions, and to adopt in good faith whatever the majority in council, after mature deliberation, may decide is best for all." If this excellent advice is followed, we may hope soon to see a forward movement along the whole line of the profession.

HAY FEVER.—The Boston Medical and Surgical Journal (August 24th), in a notice of Dr. Wyman's work, and Dr. Beard's upon hay fever, thus refers to the latter volume:

Dr. G. M. Beard, in a recent publication on hay fever or summer catarrh, claims that the two forms of catarrh occurring in June and September are identical, and, moreover, that there is an intermediate form, beginning in July, which has not been previously described. He also states that all forms of the disease in all countries are essentially the same, and all dependent on one cause, a functional disease of the nervous system, a neurosis. Dr. Beard arrives at this conclusion from the analysis of the answers to fifty-five questions with regard to the residence, temperament, hereditary predisposition, date of attack, exciting causes, nature of symptoms, etc. These questions were distributed quite extensively in the form of a circular, and answers were received with regard to some two hundred cases. One half only of the cases, however, were observed by himself or by other physicians, and in view of the liability to errors of diagnosis in cases reported by unprofessional observers, it seems as if a smaller number of cases more thoroughly investigated might be of greater scientific value. Though the author hardly settles the problem as to the nature of hay fever so satisfactorily to our mind as he appears to have done to his own, many points of interest are developed. With regard to the localities in which hay fever is liable to occur, cases are recorded from most of the States east of the Rocky Mountains, south as well as north. Some regions supposed to be exempt from autumnal catarrh are said to contain many cases of hay fever. This may be accounted for by the fact that the two diseases have different limits, or future research may show that the supposed limits require modification.

This book is in the main corroborative of Dr. Wyman's previous work. It is interesting to notice that, of the two hundred cases collected, twenty-seven were of the early or June form, nineteen of the so-called July form, and one hundred and fifty-two of the autumnal variety. With regard to

the existence of a July group Dr. Wyman says: "If this be so, the separation of the June and September groups is established. Any two groups between which there is a third must be separate. A description which confounds June cold and autumnal catarrh does not exactly suit either separately, either in the time of attack, the causes of paroxysms, the geographical distribution, or the means of relief. It may be observed that Dr. Phoebus records no distinct group in July, although he mentions that a few cases thus occur."

The theory of the nervous origin of the disease is more satisfactory than any of the other hypotheses, and is in accordance with Dr. Wyman's original suggestions, which are quoted above, but are not alluded to by Dr. Beard.

In the way of treatment, a mild galvanic current, applied both centrally and locally, is said to have proved of immediate benefit in two cases, but the particulars are not given. Dr. Hutchinson, of Providence, reported a case treated in a similar manner, in the *Journal* of November 5, 1874, which Dr. Wyman criticises by saying that the supposed cure coincided with the natural time of disappearance of the disease. Dr. Hutchinson, however, in a later communication, attributes a permanent beneficial effect to the galvanization, since the symptoms in 1875 were much milder than in previous years.

M. Vulfranc Gerdy, who was for a long time inspector of Uriage, has left a sum of money to the Academy of Medicine of Paris, to found a kind of school in which young medical men, with suitable salaries, shall, for four consecutive years, repair to such watering places as shall be pointed out to them, study and collect cases, and report upon them to the Academy. Satisfactory reports will be specially rewarded.

DOCTORS VS. DEVILS.—Lieutenant Masters, R. N., has discovered that the natives of Terra del Fuego believe in devils, and that they are the departed spirits of members of the medical profession. The main object of their religious ceremony is to keep these devils at a distance from them.

TEST FOR ASCERTAINING THE PRESENCE OF BLOOD IN CLOTH OR IN LIQUIDS.—For physicians and clinical instructors the following method of discovering the presence of blood may be useful, especially in the examination of urine: it combines simplicity with absolute certainty. Mix in a test-tube two cubic centimeters of tincture of guaiac with an equal volume of oil of turpentine, and then add a few drops of the urine which is to be examined. If it contains any blood, even in minutest quantity, the whole mixture at once shows a more or less intensely blue color, sometimes a deep indigo, while this coloration is produced neither by normal urine nor by urine containing albumen or pus. If you wish to ascertain whether stains in linen, wood, etc., contain blood, you proceed in this way: Dissolve five grammes of guaiac in one hundred cubic centimeters of absolute alcohol, and filter the solution; then mix five cubic centimeters of this solution with the same volume of rectified oil of turpentine, and put into this mixture the small piece of linen, wood, etc., the suspicious stains of which have been previously treated with warm diluted acetic acid. The presence of blood will at once show itself by a blue color.

COD-LIVER OIL AND FERROUS IODIDE.—The following formula has been published in the *Nieuw Tijdschrift voor de Pharmacie in Nederland*, by a commission appointed by the Netherlands Pharmaceutical Society, to examine secret remedies and specialties: Iodine, one part; pulverized iron, one part; pale cod-liver oil, eighty parts.

Triturate the pulverized iron in a mortar with the iodine and one-fourth of the oil, and heat the mixture in a water-bath, with constant stirring, until the brown color of the iodine has entirely disappeared and given place to a deep purple color, showing that the ferrous iodide has been formed and dissolved. Then add the remainder of the oil, mix carefully, and after standing decant into dry bottles, which are to be completely filled, closed immediately and kept sheltered from the light.